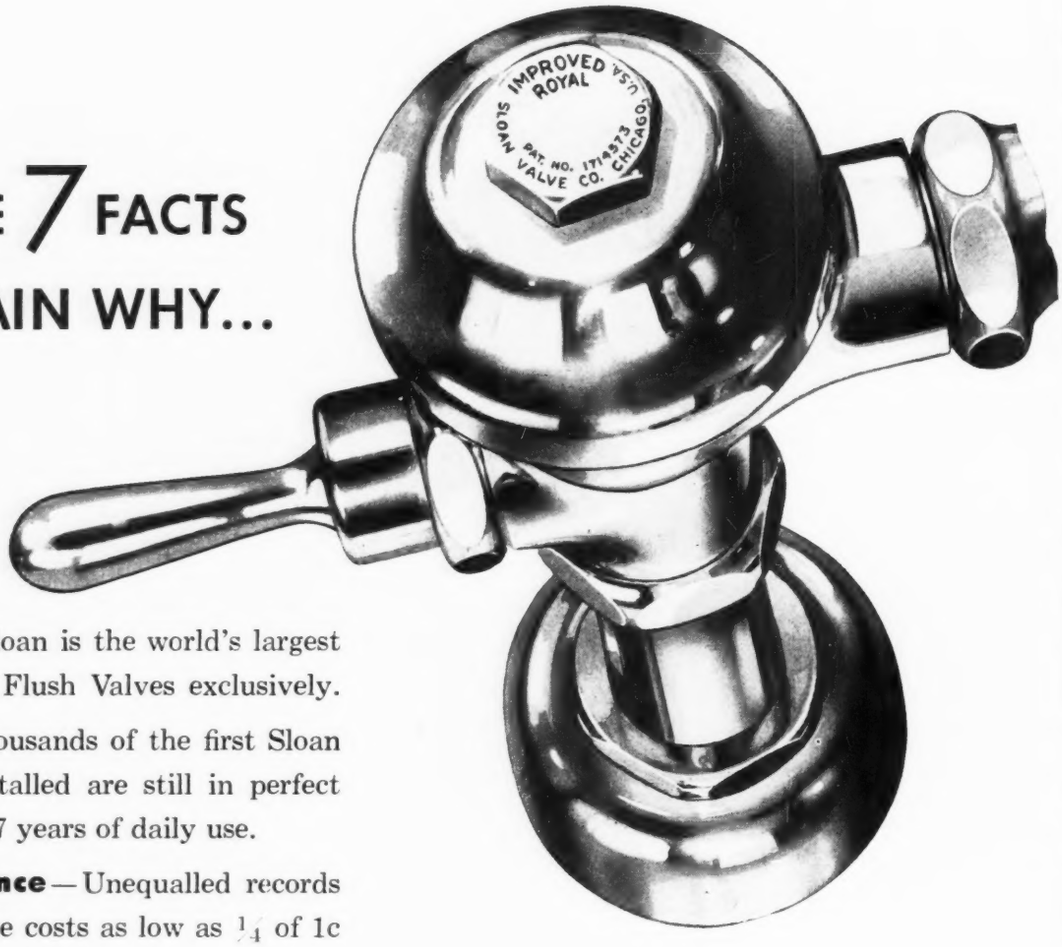
Sal[illegible]ies for Surgeons, by Bertram Bernheim, M.D.
Sta[illegible]dards for Chronic Disease Hospitals
Pla[illegible]ning the Fifty Bed Hospital

December
VOLUME 69
NUMBER 6
1947

the Modern Hospital

More *Sloan Flush Valves* are sold *than all other makes combined*

THESE 7 FACTS EXPLAIN WHY...



Reputation—Sloan is the world's largest manufacturer of Flush Valves exclusively.

Endurance—Thousands of the first Sloan Flush Valves installed are still in perfect operation after 37 years of daily use.

Low Maintenance—Unequalled records show maintenance costs as low as $\frac{1}{4}$ of 1c per valve per year.

Water Conservation—Records prove that reduced water consumption has saved enough to pay for Sloan installations many times over.

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Quietness—Without screening the water, Sloan Quiet Flush Valves are whisper quiet.

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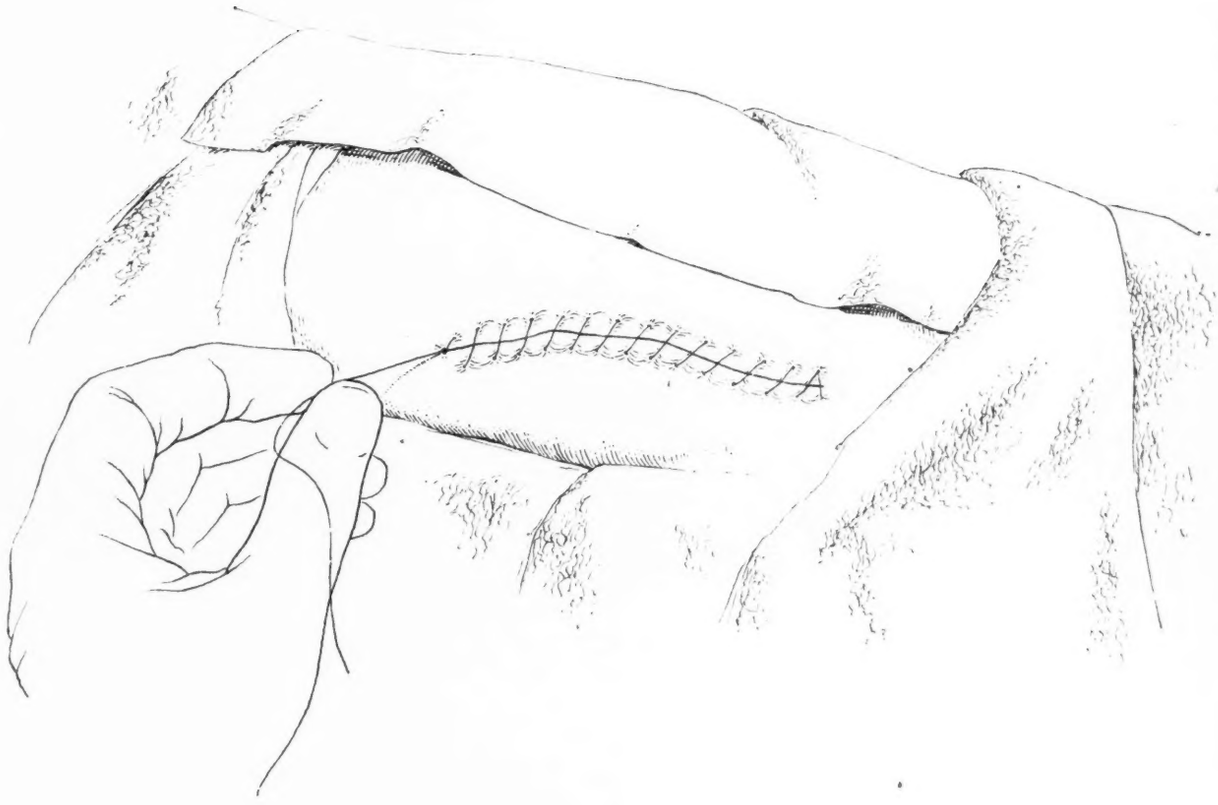
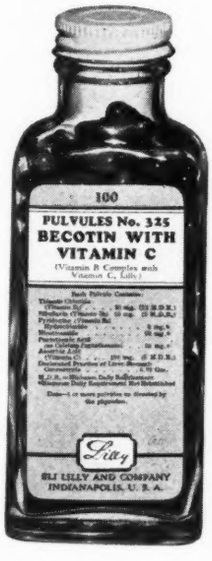


Postsurgical healing can be enhanced



In cases with an avitaminosis, wound healing can be accelerated and hospitalization time shortened by preoperative and postoperative administration of Pulvules 'Becotin with Vitamin C' (Vitamin B Complex with Vitamin C, Lilly). Following major surgery there is usually rapid depletion of the water-soluble vitamins. This is particularly true of patients undergoing surgery of the gastro-intestinal tract.

Operations of choice allow physicians time to correct deficiencies before surgery. In urgent cases, preoperative and postoperative parenteral administration of Ampoules 'Betalin Complex' (Vitamin B Complex, Lilly) and Ampoules 'Cevalin' (Ascorbic Acid, Lilly) is indicated.

As soon after surgery as the patient can take oral medication, one or more Pulvules 'Becotin with Vitamin C' may be prescribed by the physician until the patient resumes normal activity.

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One pulvule provides a therapeutic dose of all the known water-soluble vitamins.

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This Month

WE INTRODUCE....

London P. Corbett is director of personnel and public relations for the Lutheran Hospital Society of Southern California, which operates the California Hospital in Los Angeles and the Santa Monica Hospital. Mr. Corbett has been connected with the hospital field since 1939, when, as a public relations consultant he undertook a public relations project for the California Hospital. After a wartime interlude as an officer in the Canadian Army, he returned to the hospital —this time as a full time member of the staff. As personnel director, Mr. Corbett is responsible for the welfare of some 1200 hospital employes (for whom, incidentally, he has prepared one of the best employe handbooks in the business), and with the other side of his dual personality he "looks around for ways to tell the whole wide world the dramatic story of the voluntary hospital system." (See page 74 for details of how this is done.)

With the true fanaticism of the transplanted Californian (he was born in Kansas 48 years ago), Mr. Corbett believes, as he puts it, that "Californiaoregonwashington spells 'paradise.'"

Though he came from a family of doctors, **Donald C. Edmonds** had no first hand exposure to hospital work until he found himself in the medical administration corps of the army. He did personnel administration duty at several army hospitals in this country and in the Philippines during the war, then came back to civilian life in the personnel department of a Washington newspaper. As it has to so many men, however, hospital work had entered his blood; after a year he gave in to the disease and became personnel and public relations director of the Alexandria Hospital, Alexandria, Va. "I am definitely set on remaining in the hospital field," Mr. Edmonds declares today. "While personnel know-how is only a part of management, I join with many others in the belief that it is the most important part, since institutions and organizations are run by human beings, not by supplies, routines and equipment." A graduate of Purdue University, Mr. Edmonds is now studying for his master's degree in—that's right, personnel administration.

Ivy Rose Hubert, R.R.L., or Mrs. John Thoman Jr., is a graduate of the school for medical record librarians at St. Mary's Hospital, Duluth, Minn. Her first article in The Modern Hospital appeared while she was a student there. Following graduation she managed record departments in state, voluntary and county hospitals in New York, Minnesota and California, assignments which provided medical record experience in a tuberculosis sanatorium, a general hospital and a chronic disease institution.

Mrs. Thoman is a former editor of the *Journal* of the American Association of Medical Record Librarians and has served on various committees of that organization, including a term as vice president. In 1945 she began a wartime stint in Washington, D. C., with the U. S. Public Health Service, as liaison officer in the office of health information, Division of Public Health Methods.

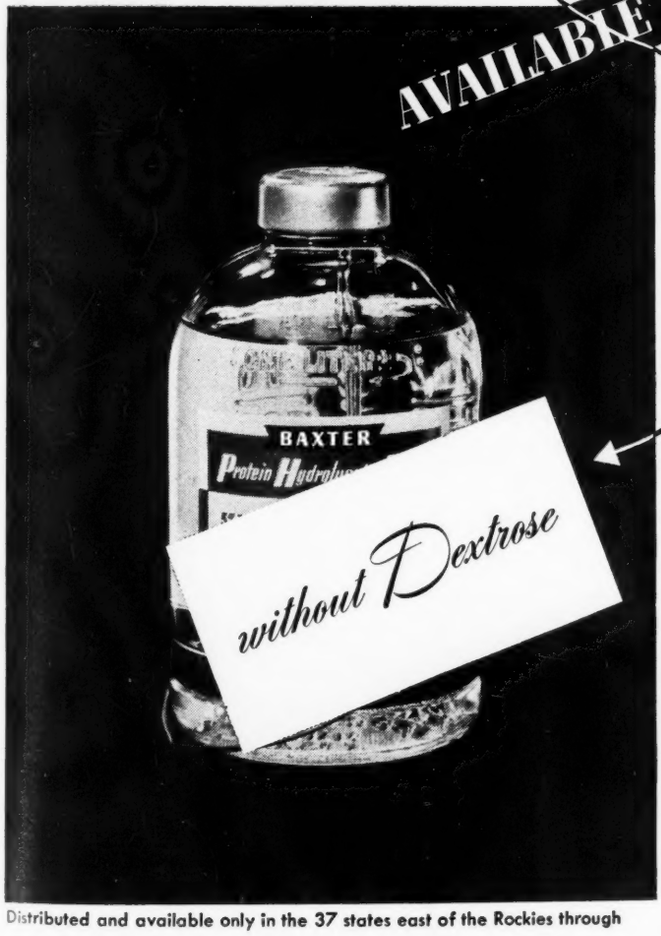
In 1946, Mrs. Thoman returned to San Leandro, Calif., to become a "household executive" but soon found herself involved in organizing a medical record system for a group of physicians managing a prepaid medical plan. This career was cut short by the arrival of a son and heir. Today, her avocation of writing still goes on from a typewriter desk in the corner of the nursery.

Eloise Ross, staff dietitian at Barnes Hospital, St. Louis, is a graduate in nutrition and dietetics from the University of Illinois in the class of 1941. Following graduation she took a dietetic internship at Montefiore Hospital, New York City. She was commissioned in the Army of the United States in August 1942 and served three and a half years, stationed at Jefferson Barracks, Missouri, Liberal, Kan., and Fort Worth, Tex. At the latter two posts, she not only acted as hospital dietitian but also assumed the responsibilities of hospital mess officer. On release from active service, she accepted her present position at Barnes Hospital. In addition to her duties as supervisor of formula preparation at Barnes, she is also in charge of ward kitchen personnel, an assignment which includes arranging work schedules and inspecting sanitation.

J. M. Crews, administrator of Methodist Hospital at Memphis, Tenn., first became acquainted with hospital work when he started as chief engineer at the hospital in 1936. He served in this capacity until 1940, when he was appointed assistant superintendent under Dr. Henry Hedden, who died in July 1945. In September 1945 Mr. Crews was officially appointed administrator, the position he still holds. Various organizations connected directly or indirectly with the hospital field have engaged his interest. Mr. Crews became a member of the American College of Hospital Administrators in 1945, served as secretary of the Memphis Hospital Association in 1942 and 1943 and as president in 1944 and 1945. He was first vice president of the Tennessee Hospital Association in 1947. He is now a director of the Tennessee division of the American Cancer Society and was instrumental in the organization of the Memphis Hospital Service Association (Blue Cross).

Protein Hydrolysate Baxter

AVAILABLE TWO WAYS



For flexibility in protein hydrolysate therapy, Baxter gives you two solutions—5% Protein Hydrolysate and 5% Protein Hydrolysate with 5% Dextrose. Autoclaved to assure sterility, these solutions meet the same high standards applied to all Baxter products.

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THE ROVING REPORTER

Look at This Manual First

Add to the small list of employe manuals you should see before you publish or republish one of your own New England Deaconess Hospital's "Glad to See You!" It is the sort of booklet that, without attempting a sales message, makes one hanker for a job in that institution.

Warren F. Cook, the administrator, has written a simple and appealing foreword, ending with:

"You are one of the links in the chain which each day saves lives. If you fail the chain may break. We need you. We are depending on you. We want you to be happy here and stay a long time. We are all—GLAD TO SEE YOU!"

Before the new employe finds out his privileges and responsibilities, he is told a little about "Yesterday's Hospital." Perhaps your own institution has just as interesting a history if you would dig back into the human interest items. As for the past of New England Deaconess we learn that:

The original hospital, a red brick residence, had five floors and 14 beds. There were no elevators. Nurses and doctors carried patients up and down a steep and narrow staircase.

Only one clinical thermometer was provided. If someone on the fourth floor, for example, wanted the thermometer he rang a bell four times and the thermometer came up in a basket on a pulley.

The first operation performed in New England Deaconess was done by a woman surgeon, assisted by a woman physician and two of the blue and white clad Deaconess nurses.

The superintendent of nurses often slept on chairs in her office in order that a patient might have her bed, a significant tribute to the New England Deaconess since hospitals generally were objects of dread in pre-20th century days.

But Their Hands Are Smaller

There are so many tall girls nowadays that special dress shops or departments cater to their tastes and sizes. Men are taller, too, than they were a generation ago. Manufacturers of nurses' uniforms and interns' garb have noted the difference.

How, then, can you reconcile this fact with a recent report from a rubber goods manufacturer that the most popular glove size is smaller than it used to be? Before the war the size of rubber gloves most in demand was size 8; today it is 7½.

The B. F. Goodrich Company reports this surprising fact, mystified as to the reason. Can it be that our brains are getting heavier so our hands can be lighter? Probably not!

Each Club Has Its Day

Walk into the lobby of Children's Orthopedic Hospital, say, on the second Wednesday of the month and you will see a poster displayed there proclaiming that this is Town and Country Club Day. The next day may be some other sponsoring organization's day, a fresh poster announcing same.

Under a new hospital support plan, Seattle and Puget Sound organizations

are being "allowed" to assume the expense of a given number of beds on a given day of the month. An $11 contribution pays for a day's care at the orthopedic hospital, according to today's rates.

The Town and Country Club, for example, has pledged itself to care for 30 patients on its day every month. On the opening day of its monthly sponsorship arrangement this club sent its orchestra to the hospital to play nursery songs, furnished ice cream and balloons to all the children, gave hair ribbons to girl patients and comic books to boys.

Another stunt for financing Children's Orthopedic is the *Seattle Times'* scheme of having citizens send the hospital their outmoded Seattle transit system tokens. These are redeemable at cash and some $1500 worth have been turned in to the hospital.

Most of the tokens are sent through the mail in small driblets. The local post office soon caught on and now when a playful citizen pastes a token on an envelope with transparent tape and perhaps draws a crutch below the token that is all the address needed to ensure the arrival of the envelope at the hospital's front entrance.

Children's Orthopedic, you may remember, has the unique distinction of once having been designated "Seattle's First Citizen" in an annual recognition ceremony.

Appreciation Brings Applicants

There is more than one way to recruit nurses just as there is more than one way to kill a cat. St. Barnabas Hospital, Minneapolis, is interested in live nurses rather than dead cats and if its school has more applicants than it can accept it is not due to the element of chance. Director Nellie Gorgas, Supt. Martha C. Lockman and an alert board of directors have been active in a dozen ways to create public interest in the school of nursing.

This last autumn, to cite one example, brought the 50th anniversary of the school of nursing. Miss Gorgas and Miss Lockman decided to tie an anniversary celebration in with the annual graduation of student nurses, scheduled for September 20.

The 800 alumnae of the school were individually contacted and invited as guests of the hospital at a smörgåsbord dinner the evening of the graduation ceremonies.

Local alumnae helped plan all the details of an alumnae homecoming. Three hundred alumnae showed up, some of them traveling long distances. Minnie Paterson, the first graduate, was there in a duplicate of her original uniform. Aberdeen, Wash., where for more than forty years she was a school nurse, got wind of the celebration and citizens there air-mailed the hospital a scrapbook of testimonials, which was presented at the dinner.

Two hours before the dinner, the local alumnae gave a tea for the graduation class, its patrons and the girls' friends. The girl graduates acted as hostesses at the alumnae dinner and the alumnae reciprocated by going to the graduating exercises. Every living member of the class of 1902 was present at the 50th anniversary dinner.

Letters are still coming in from alumnae telling how much they appreciated the reunion. The newspapers gave the event quite a play: news stories, pictures and one feature article. At the time when nurse recruiting was necessary, the anniversary celebration tied to the graduating exercises showed the public how much the hospital appreciates its nurses and alumnae.

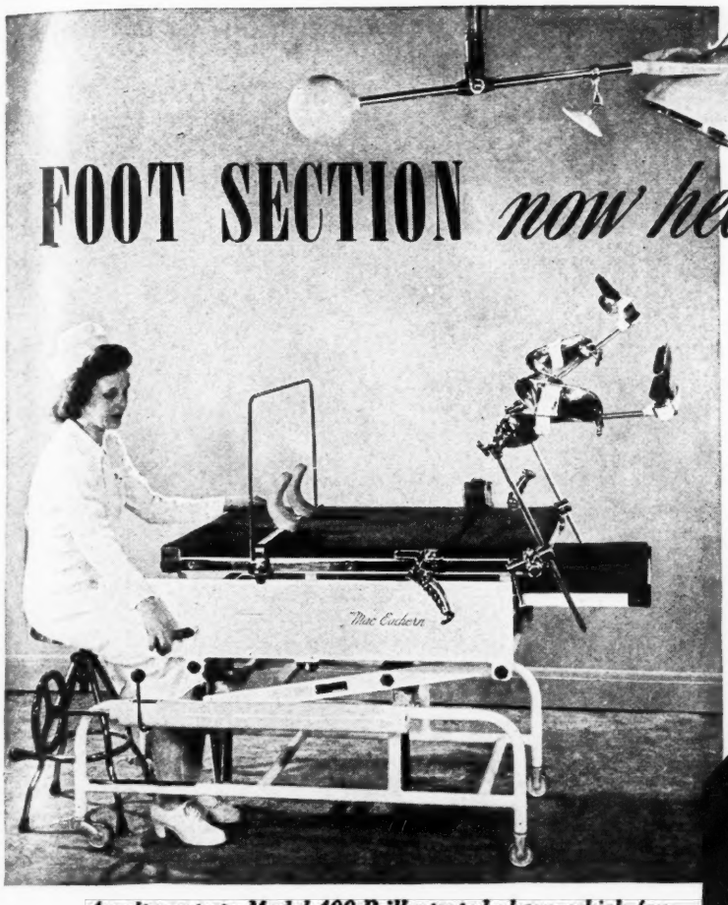
Regulating Medical Staff

Hospitals wishing to amend their medical staff and hospital rules may wish to get a copy of the new "By-Laws, Rules and Regulations of Brooks Memorial Hospital" at Dunkirk, N. Y. A fellow rover says they are well done and that this is a "damn fine hospital."

FOOT SECTION *now head-end controlled*

...crank operated from either side of Table

Greater posturing latitude, operating precision and time-saving conveniences afforded by the new MODEL 400-B.



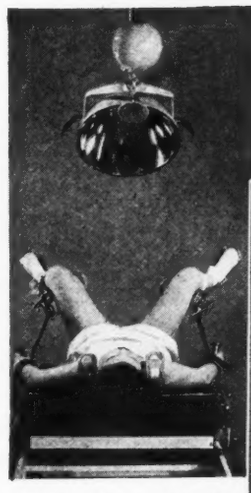
An alternate to Model 400-B illustrated above, which features a pedestal base with hydraulic lift, is now also available as MODEL 500.

MACEACHERN OBSTETRICAL TABLE

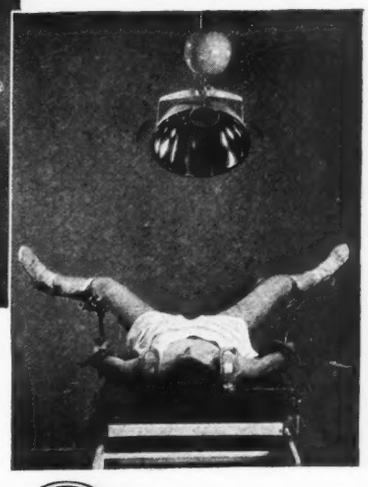
A NEW INNNOVATION MEETS THE LEG-HOLDING PROBLEM—one master control, by a unique universal type socket, provides for the first time on any surgical or obstetrical table INWARD as well as outward lateral adjustment of the leg-holder post.

This engineering achievement . . . the development of an entirely new type of universal joint . . . positions the leg in every known obstetrical posture from Lithotomy to Walcher, regardless of how tall or how short a patient may be. Equally important, patients are thus positioned in absolute fixation. LEG-HOLDING IS NOW ATTAINED BY THE FASTEST, SIMPLEST AND MOST PRECISE METHOD KNOWN.

CRANK-OPERATED FOOT SECTION is now controlled on MacEachern 400-B Tables by anesthetist or nurse *from either side* of Head-End of Table. Foot-section can be partially or fully recessed, or extended as required, without interruption to the obstetrician. The Foot-section, functioning as a "Utility Shelf," is promptly revealed to receive the infant or serve as an instrument tray in the closing of episiotomy or other repair work. THIS SUPERIOR TABLE FEATURES HEAD-END CONTROL THROUGHOUT.



Observe inward and outward leg-spread adjustment showing 4' 10" model (photo above) and 6' model (photo at right).



Note simplicity and practicability of Comper Knee and Foot Rests which absorb pressure on soles of feet rather than delicate vessels under knees.

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READER OPINION

V.A. Hospital Program

Sirs:

I thoroughly enjoyed your able "Convention Digest" with the exception of the report on the delegates' resolution against "unlimited expansion of the veterans administration hospital system." From what I have heard, the V.A. hospital construction program, far from being as described, is sadly limited and proceeding at a dreary pace that represents no great threat to anyone except veterans in future need of medical care.

The rebuke seemed a little misdirected and confused, since the Bradley-Hawley administration has steadfastly refused to expand beyond the availability of personnel to give good quality medical care. Instead of asking Congress to hold up appropriations until needs are established, as if the V.A. were trying to get away with some kind of empire building stunt, the resolution should have criticized Congress for sticking to old laws placing a pressure for expansion on the V.A. which will rapidly exceed its ability to deliver a high standard of service.

Hawley's greatest hope is that Congress will set a reasonable limit on his responsibility for hospitalizing veterans —which now extends as beds become available to all sick veterans who sign a piece of paper saying they cannot pay. He is actually caught in a switch between good medicine and good politics. The reverse of the attitude expressed in St. Louis was recited to me recently in a community where non-V.A. hospitals are turning away veterans, whether they are service connected or not, even when the V.A. has no bed available. Veterans are civilians, too. Of course, when people come to passing resolutions against what they dislike it is probably too much for them to act on the basis of information. It would spoil the fun of getting indignant.

Greer Williams

Arlington, Va.

Greer Williams is a special consultant in the Veterans Administration Department of Medicine and Surgery. His article on General Hawley and the V.A.'s medical-hospital program appeared in a recent issue of the "Saturday Evening Post."—ED.

Missed the Point

Sirs:

In your September number, in the Small Hospital Questions, we believe your commentator entirely missed the point in asking, "What possible concern can a hospital have in the question of whether patients are examined by the staff radiologist in the hospital department or in the private office of a radiologist?"

In the first place there is the quality of technical ability to be considered. In many instances the technicians of the private practitioner are inferior in ability to those employed by a hospital, both in the clinical laboratory and in radiology. The same holds true of the professional men themselves. Therefore, for a hospital to accept all findings of outside offices as final for their own patrons is not only extremely foolish but downright dangerous. This holds true especially in clinical laboratory findings.

From the financial standpoint as well, if the departments of any hospital are operated as they should be they should show a surplus after determining square foot rental of the department space used, salaries, other emoluments given employes, service or utilities used, supplies and all other expenses. There are few hospitals whose ward and room rates are sufficient to carry their cost in nursing and supplies; therefore the income departments, such as x-ray, laboratory and drug room, must make enough to offset any deficit on rooms or wards.

Then to allow any doctor or patients to purchase examinations or supplies outside the institution that may or should be given within is a direct loss to the hospital and never should be allowed.

Any doctor persisting in such a practice at an economic loss to the hospital should be barred from its facilities.

R. D. Brisbane
Administrator

Sutter General
and Maternity Hospital
Sacramento, Calif.

The Hospital Menace

Sirs:

I have read the article, "How Can the Hospital Control Medical Quality?" in the September issue of The MODERN HOSPITAL. I was sympathetic with Mr. Mac F. Cahal but I believe he failed to state his case diplomatically enough. There is no question regarding the tendency of modern hospitals to profit from the professional ability of certain employes. Many radiologists are being exploited in the same manner that pathologists have been exploited for years. I also admit that some radiologists also attempt to exploit the hospitals. Some satisfactory and honorable arrangement should be recommended.

Reader's Name Withheld

SMALL HOSPITAL QUESTIONS

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Me., and others.

Methods of Promoting Harmony

Question: What can be done in the small hospital to promote good relations between the board of trustees and the medical staff?—E.A.Y., Wis.

ANSWER: The most effective medium in establishing good relations between the board of trustees and the medical staff is to keep each group informed as regards the policies, ambitions and problems of the other. One excellent method is to have a dinner to which members of both groups are invited for the purpose of hearing a speaker talk to them of their mutual problems. On one occasion it is good to have a speaker who might be an outstanding hospital trustee and at another time it might be well to have an outstanding physician. It is better to have these speakers come from outside the local area of the hospital, for then they can present new ideas that have been developed and challenges that have been successfully met in other institutions.

At such a dinner, I should arrange for equal distribution of the medical staff and the board of trustees at each table and would give close attention to the seating arrangement, being careful to group trustees and physicians who are not too well acquainted. I should suggest that the hospital sponsor these dinners; however, I have seen successful occasions of this kind sponsored by an individual member of the staff or board of trustees.

Another effective medium is to have complete informative reports from the chief of staff to the board of trustees regarding the activities of the medical staff and a similar report by the administrator to the medical staff covering the problems of administration. Joint conference committee meetings are an effective means for ironing out problems, but they should not be depended upon to do the whole job.—WILLIAM J. DONNELLY.

Standardize and Simplify

Question: What is the best procedure to follow in introducing a program of simplification and standardization in a hospital?—N.I.J., Neb.

ANSWER: Before a program of simplification and standardization of hospital equipment and supplies can be instituted, it is necessary to have an active committee of staff doctors and nurses work on the problem of the simplification and standardization of professional procedures. An article by Doctors Campbell, Etsten and McClintock on work being done in the operating rooms of the Albany Hospital, Albany, N. Y., in the September 1947 issue of The MODERN HOSPITAL is an excellent illustration of the kind of work that must be done before equipment and supplies can be simplified and standardized.

A little study will disclose which items of equipment and supply account for the biggest portion of the expense dollar. The program might well be started with five or ten of these principal items. Certainly you should be familiar with the items on which simplified practice and commercial standard recommendations have been made by the National Bureau of Standards, working in cooperation with the purchasing, simplification and standardization committee of the American Hospital Association.—E. W. JONES.

Don't Shake the Mop

Question: What do you consider the best method of handling dry mops? We have found shaking them out on fire escapes and exits unsatisfactory and have also found any containers now on the market rather unsatisfactory.—F.J.B., Vt.

ANSWER: My conception of the purpose of a dry mop may differ from yours. Dry mops are used for mopping waxed floors, when the polishing machine is not indicated, or clean surfaces. In these cases little or no shaking is required and, as they become soiled, the mop heads can be removed and placed in the laundry. The purpose of the dry mop is defeated if it has to be shaken when in use.—JEWELL W. THRASHER.

Problems of Contagion

Question: How can the small hospital provide care for communicable disease, tuberculosis and chronic cases?—T.I.V., Calif.

ANSWER: The secret of the care of communicable disease and tuberculosis lies with good isolation and nursing technics. Whether or not small hospitals care for chronic cases is a matter of their basic philosophy and their community responsibilities.—ROGER W. DEBUSK, M.D.

Who Shall Purchase?

Question: How can the superintendent of a small hospital delegate some of the purchasing and storekeeping?—A.M.H., Ill.

ANSWER: The superintendent of a small hospital almost has to centralize all purchasing activities in his own office. However, it would seem that storekeeping records and the issuance of stores might be delegated to an office manager, the housekeeper or, possibly, the engineer and general all-round mechanic. By and large, the administrator in a small hospital is burdened with entirely too much detail, with the result that he does not have time to think out management problems and to perform an overall executive function.

It has always been my belief that all hospitals of 30, 40, 50 or 60 beds, on up to 100, which do not now have a full time pharmacist could save money by putting their drug therapy on a sound and economical basis through the employment of a full time pharmacist. The same person could then handle purchasing and storekeeping.—E. W. JONES.

Practical Nurses' Salaries

Question: If practical nurses are given only one year of technical training, what salary would you pay them in relation to that paid to fully trained nurses?—S.Y.A., Ohio.

ANSWER: The status of qualified practical nurses in federal nursing services has not been determined at this time, but it has been proposed that practical nurses who have completed a year of approved training will be classified as "subprofessional" at an annual salary of $2168. Professional nurses for staff duty are now classified as "professional 1" at an entrance salary of $2644 per year.—PEARL MCIVER.

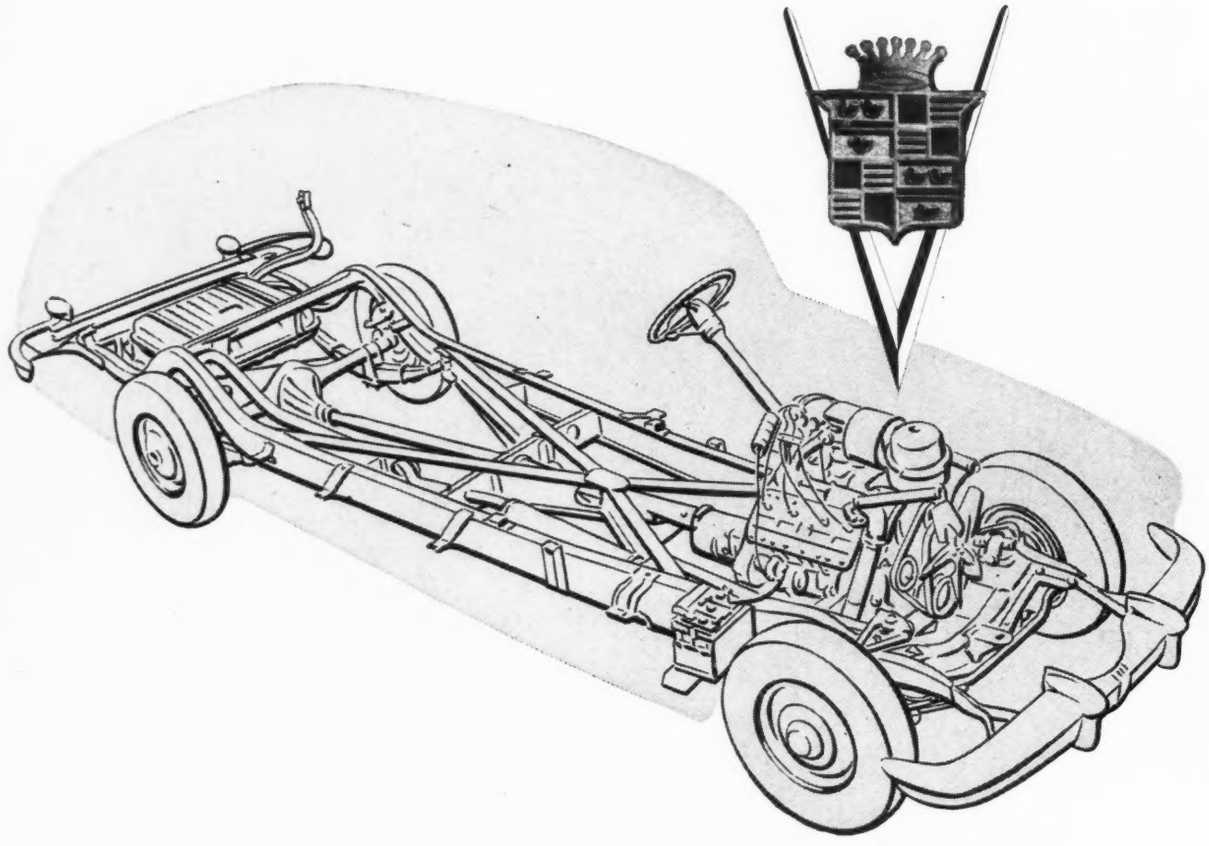
No Compromise on Quality

Question: Do you think that the purchasing agent, or hospital administrator, should compromise on quality and color in dishes now when prices of porcelain are high?—O.L.V., Fla.

ANSWER: The answer as to whether one should compromise on quality is always the same, "no."

With regard to color or design, it might be well to select less expensive designs as frequently the same quality of china can be purchased for much less when an inexpensive pattern is chosen. One must think, however, of the expense involved in arranging for a completely new china service and also the desirability of having china service in an "open stock" pattern.—WILLIAM J. DONNELLY.

CADILLAC



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Unique in the field of ambulance and funeral car service, the Cadillac provides a foundation without equal. It offers you the only commercial chassis that is especially engineered and built for your special purposes by the company whose name it bears. The famous Cadillac V-type engine insures smooth, dependable power—the General Motors Hydra-Matic Drive, performance that is beyond comparison.

And the Cadillac name represents an incomparable foundation for the business it serves. When you specify "Cadillac" you buy more than dependable transportation—you acquire that *exclusive* business prestige that accrues from the great Cadillac name. Coachwork by America's finest commercial body builders, listed below, is available in a wide range of types and styles to meet your own requirements.

The Eureka Co., Rock Falls, Illinois • The A. J. Miller Co., Bellefontaine, Ohio • The Meteor Motor Car Co., Piqua, Ohio
Superior Coach Corporation, Lima, Ohio • Hess & Eisenhardt Co., Rossmoyne, Cincinnati, Ohio

LARGEST MANUFACTURERS OF COMMERCIAL CHASSIS FOR FUNERAL CAR AND AMBULANCE USE

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LOOKING FORWARD

The Greatest of These

AS THE traditional season for looking into the future approaches, hospital philosophers are polishing up their crystal balls, which will presently reveal, in the amiable fashion of crystal balls, whatever images each crystal gazer would like best to see.

* * * *

Peering deeply into the future, for example, the more optimistic among the seers may see a shining thing called the hospital of the future—a beautiful structure, scientifically planned and oriented to sunlight, staffed by a competent corps of energetic men and women, integrated with other agencies in a regional health care system. In this happy scheme, hospital trustees are invariably public spirited citizens with a comprehensive knowledge of hospital procedures and deep awareness of their responsibilities. The administrator discharges his many tasks with matchless efficiency, glancing up occasionally at an elaborately framed diploma which proclaims that he is a Doctor of Hospital Administration. On the floors, physicians ply their skills with full understanding and consideration for the hospital's problems of income and expense. Nurses abound.

There is one odd thing about this hospital, however, which can be seen only by the most searching eyes: The patients are all faceless. This puzzles the crystal gazers, but only momentarily. After all, faceless patients are not likely to complain—if there could be anything to complain about, that is, in such magnificent surroundings.

* * * *

Looking into our own crystal, we see a vastly different picture of the future. Close at hand are mounting piles of hospital brick and mortar—evidence that the looked-for expansion of hospital plant is a fast-growing fact. At the same time, other hospitals are sadly closing doors and turning away patients for lack of help. For as far as we can follow them, costs are spiraling upward, breathlessly pursued by hospital rates, which never quite catch up.

We see a hospital, too—an ordinary mixture of new and old buildings, good and bad planning. In the front office of this hospital, the administrator sits late at his desk, ringed in by a circle of angry men and women. These prove to be doctors, nurses, department heads, trustees, union representatives, Blue Cross executives and government officials—all talking at once and shaking their fists at the administrator.

In the beds of this hospital, however, are real people instead of faceless shapes. Some of the patients, to be sure, are frowning like petulant children. Others are grimacing with pain. But here and there in the wards we see smiling, happy faces—a woman whose doctor has taken the time to answer her timid questions carefully, with reassuring kindness; a child listening to a story read by a nurse who was supposed to go off duty twenty minutes ago.

Taking a last look at this ordinary hospital, we see a change in the administrator's office. The angry crowd has filed out, and the administrator sits alone at his desk. His worried look has vanished. In its place is an expression radiant with inner spiritual satisfaction. On the wall behind him is a simple motto: *And now abideth faith, hope, charity, these three; but the greatest of these is charity. . . . Charity suffereth long and is kind; charity envieth not; charity vaunteth not itself.*

Expensive Folly

THE 1948 campaign to recruit student nurses is about to roll, with more space in more papers and more time on more stations, as planned by more people with more advertising contacts. It will cost more money, of course, but its sponsors point out that it will also save more in contributed space and time—an argument faintly reminiscent of the vendor who lost a little on every hot dog but didn't mind because he sold so many.

Unquestionably, the campaign will recruit more student nurses, thus filling classroom seats that might otherwise be empty and possibly cranking up some beds that might otherwise go uncranked. For all its talented schmaltz, however, the bigger and better advertising campaign is not likely to solve any of the basic economic problems that made it necessary. In fact, there is a growing feeling that in the long run it may make these problems worse. Masking the symptoms rarely hastens the cure.

Possibly the best way to find out what is wrong is to get behind the nurse for a minute and look at the

patient, who is now paying $10 a day and up for hospital care. For that kind of money, he certainly ought to get somebody to rub his back if he wants it rubbed and somebody else to protect him if he doesn't. The question then is, should he pay $10 to have a graduate nurse do the rubbing while a supervisor stands guard, or something less than $10 for a practical nurse to rub and a graduate to watch?

Unless he wants his nurse to read the materia medica to him while she rubs his back, it seems likely that the average patient would choose to pay less. Every study of nursing procedures that has ever been made indicates that from half to three fourths of the work performed by graduate general duty nurses in hospitals can be done by girls with a year or less of practical nurse training. To the extent that this is true, the patient is paying for something he doesn't need and doesn't want—a backrub with scientific overtones.

As long as nursing practice includes such inconsistencies, it is probably a mistake to recruit girls into nursing schools by high pressure advertising. For many of these girls, the advertising promises more in the way of a career than the economics of medical care will permit hospitals to deliver. Hospitals which justify the advertising on the ground that it will fill their wards with students who work for nothing are deluding themselves even more than they are the students, which is saying something. Whatever it may do for the immediate economy of the individual hospital, pumping more and more nurses into jobs as sub-nurses is going to cost somebody a lot of money eventually.

Paying professional nurses to do housekeeping, clerical and minor nursing chores is expensive folly. For years, its cost has been passed along to the patient, who doesn't know what he's paying for anyway. This can't go on forever.

Performance Audit

JUDGING the performance of hospitals is a tricky business, as every administrator knows. There is no yardstick. The balance sheet is useless, because a favorable financial situation may reflect nothing more than failure to provide adequate care for patients. Autopsy and mortality rates, significant within limits, may be affected by special circumstances having little to do with the general quality of hospital care. Nursing hours per patient day mean little, because there is no satisfactory way of measuring nursing quality.

Unquestionably, the point rating system recently developed by the American College of Surgeons provides the most comprehensive and penetrating means of measuring hospital quality that has yet been developed. Administrators and trustees can be satisfied that a high score on the new "hospital standardization scoring report" means that high quality care is being delivered, and a low score means something is wrong.

Even this system, however, doesn't tell the whole story. The college is interested in professional standards; its point system is not concerned with economy. A high scoring hospital may be spending far more than is necessary and, to this extent, wasting community resources. At this point, the balance sheet comes back into the picture. Probably the best total evaluation that can be obtained would result from a study of the hospital's standing in all features of the college standardization report, combined with a detailed analysis of its costs and possibly some attention to its general reputation among informed people in the community.

Obviously, not many hospitals ever submit to this kind of complete evaluation of performance, except perhaps when circumstances call for the services of a seasoned consultant. Short of taking this step, hospitals generally might do well to establish an annual "performance audit" to be carried out by a committee representing the board of trustees, medical staff and administration. Among other things, this practice might prevent some unjust judgments of administrative performance by board and staff members who see only a fraction of the whole picture.

De Gustibus

THE reappearance recently of "Insides Out," by John Mason Brown (New York: Whittlesey House, 1942. $2), makes one wonder at the public taste. This volume is subtitled "the saga of a drama critic who attended his own opening." The subtitle is a fairly accurate barometer of the quality of humor that is achieved in this patient's account of a hospitalization experience. Here and there a flash of penetrating wit emerges from the heavy clouds of effort, as when the resident is described as "a young man suspended halfway between his professional hopes for the future and his vivid memories of medical school," or when the overbed table "stands on the alert at the foot of the bed, designed to crawl backward and forward over my dry-docked body like a traveling crane." Another shrewd observation which should make sensitive hospital people blush is the reference to orderlies as the "untouchables of the hospital caste system."

For the most part, however, the author strains doggedly at humor like the master of ceremonies in a second rate night club, speaking of the hospital as a "Hippocratic flophouse," leering adolescently about the "enforced intimacies" of hospital life, dredging up those labored ironies about requests for information at the admitting desk and dropping leaden quips about meals, morning care, surgery, visitors, flowers and all the other timeworn targets of hospital clowns.

Of course, people in any occupation or profession are likely to be a little touchy about jokers who make light of their chosen calling. Obviously, these wisecracks must seem drearier inside the hospital than out, or nobody would have bought this book, which is now issued in its seventh printing, except the author's fondest friends. His very, very fondest friends.

A Surgeon Says:

"Surgeons Should Not Engage in Private Practice"

BERTRAM M. BERNHEIM, M.D.
Baltimore

THE idea of control is abhorrent to free men, particularly here in America where there has been so little of it. We have been accustomed to doing as we pleased so long that it comes as a shock to suggest that maybe it hasn't been for the best in all lines of endeavor and the time has come for some downright thinking on the subject.

In a recently published book, "A Surgeon's Domain,"* I advocated the complete elimination of surgeons from private practice. The matter had long been in my mind and indeed I had offered the suggestion in previous publications—with scant attention from laity or profession. This time it occasioned considerable interest and there can be little question that it stems from the latter day awakening of people to the problems of medicine coupled with a realization that something is vaguely wrong and needs correction.

I didn't expect the doctors to agree with my thesis and was not disappointed at their objections. I didn't know what to expect from the laity and wondered if they would grasp the implications. They did and most definitely fell in line with the views expressed. It is but another illustration of the people being ahead of the powers in their thinking.

Perhaps I should say that I don't like control either, but I like still less the way the medical profession goes right along clinging to practices that might have had merit years back but cannot possibly meet modern conditions. Other groups see the wisdom of making obvious changes; why can't we?

Take the problem of surgery or, better, the business thereof. Any line of endeavor by which men make money must be regarded in the light of business. The only difference is in kind and I should say society has treated the doctors with the utmost consideration—in certain respects too much for their own and its own good. Merely the granting of a license to practice gives the doctor complete freedom of action, quite without regard to qualifications other than the single one of graduation from a medical school. No demand is made for renewal of license from time to time—with reexamination; no demand is made for refresher courses or study of any kind. Once a doctor gets a license it is for life and no man has the right to question his acts. This, together with the ethics of the medical profession, confers on him an immunity enjoyed by no other member of society and that is why hospitals and medical societies are so helpless in trying to control him.

The rarest thing in the world is to see a doctor hauled up before a medical society and dismissed for doing bad work, and medical boards of hospitals hesitate long before taking forthright action against men who have committed glaring errors. These boards are composed of doctors; there is always the danger of legal action; they are always afraid they themselves might commit some breach—and even if they do dismiss a man he can always catch on with another hospital. I am being perfectly frank.

Dr. Bernheim

Bertram M. Bernheim, M.D., is associate professor of surgery at Johns Hopkins Medical School and a member of the staff at Johns Hopkins, Union Memorial, Women's and other hospitals in Baltimore, where he has practiced surgery for forty years. He was one of the founders of the American College of Surgeons and the American Board of Surgery and has written textbooks in his special field, surgery of the blood vessels.

Dr. Bernheim is also the author of several popular magazine articles and books. Most recent of these was "The Surgeon's Domain," winner of last year's Norton Award for books about the medical profession.

W. W. Norton & Co., New York, 1947.

The problem is fundamentally one of business and the law says that of the doctor is his own. He can do medicine, surgery, pediatrics, orthopedics, eye work, allergy or all of them and more combined, and it is still his own affair. It is true that hospitals have something to say about it but loads of work isn't done in hospitals. Furthermore, the restrictions imposed by too many hospitals are anything but strict.

Of course, if a doctor has a death the coroner can make investigation but even there you see extreme hesitancy to pin anything on a man and, if the truth be faced, there aren't so many outright deaths that are perpetrated. In other words, actual deaths are not the big trouble. The big trouble is bad medicine, bad surgery, too much surgery, unnecessary surgery and moral delinquency, by which I mean buying and selling work.

Efforts Have Been Inept

The medical profession has not been oblivious to problems and its own duty in the premises but the efforts it has made to control things have been lumbering, slow, inept and grossly ineffective. Certain features like that of the license and its ethics have not even been touched upon. The one of medical education, the elimination of proprietary medical schools and the strengthening of all those remaining has been excellent, but it was the easiest and simplest thing to do.

The raising of hospital standards has been good, too, but slow and too often perfunctory in character. Furthermore, it doesn't go far enough in that hospitals that fail to come up to requirements remain in business and all kinds of medical and surgical work continues to be done in them. Indeed, that is where lots of the dirty work is perpetrated but by no means all. Plenty of it goes on in the standardized regulated institutions.

As for the American College of Surgeons and the American Board of Surgery, the less said about them the better, and I was one of the founders of both. Men don't have to belong to either to obtain privileges in countless hospitals and so long as that situation is permitted to exist it is idle to expect much good to come from them. To make matters worse, the standards of the American Board of Surgery are so high that most men couldn't think of passing them. Since they don't have to be certificated to get jobs and to operate — except in certain hospitals — why bother?

One might as well be realistic. If the powers took a more practical view and if all hospitals could be brought to give privileges only to the anointed, there is no doubt that over a period of years improvement would come to pass. But who thinks that will happen, and how long will it take? More to the point, how great will be the human cost in the meantime?

I do not decry the efforts made by the medical profession. I merely say they have been shockingly ineffective and all the time the human cost continues and is mounting. To my way of thinking we have regarded the latter too little and too lightly. We have talked and acted far too much in terms of ourselves, our own

"Many Will Agree":

BASIL C. MacLEAN, M.D.
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Dr. MacLean

MANY will agree that there is merit in Doctor Bernheim's thesis, but few have the courage to say so. It is quite apparent to anyone who examines carefully the clinical records of many hospitals that too much meddlesome and unnecessary surgery is still done. Too much surgery is done by men whose main qualification is an aureate itch for the drama and the ritual, for the sycophancy of the uninitiated and for the fee. Of the scandalous disparity between the monetary rewards of surgery and of medicine, no more need be said.

Dr. Bernheim would burn down the barn of private practice to get rid of the rats, but perhaps he deliberately overdraws to make his point. A much needed revision of licensure laws to require that surgery be done only by trained surgeons may still be too distant. Meanwhile, the nonmedical trustees of a voluntary hospital, who have the ultimate responsibility for work done in that hospital, must rely on professional rating bodies or on the advice of some physician who has lived long. Too often the chosen adviser is a charlatan with an impressive manner or a good golf score. All this is more of a problem, of course, in the small hospital than in one where a doctor's doings are under the scrutiny of numerous professional colleagues. Among the latter, not the least important are the interns and residents and, in a teaching hospital, the medical students. Young men in training are fairly quick to detect the quack and the crook. In the average hospital, the best insurance for honest surgical practice is the presence of a competent, courageous pathologist.

In spite of the shortcomings of our present system, one must admit improvement during the last three decades. The certification of specialists and the approval programs of professional groups, while not perfect, have accomplished much. The growth of group practice is encouraging, even though there may be some heels among group healers. The point is that the average citizen is more sophisticated than his father in things medical and may be more intelligent in his choice of a group than of an individual.

Doctor Bernheim correctly lays the ghost of the salary system bogey. One of the most stupid sophistries of the medical politician is his insistence that good quality of medical care in hospitals can be obtained only when bought piecemeal by the patient. Many thoughtful observers hold, however, that the more costly multiple system of medical fees is the surest path to governmental intervention.

The greatest hope on the horizon may be in the regional plan of hospital care. Some small hospitals have splendid staffs and high standards. Many are a menace. For these an affiliation with a larger and professionally stronger hospital or medical center offers much in medical education and in raising the level of medical and hospital care. The next decade may see a development in this direction. It is an opportunity for doctors to do the job themselves. Otherwise a less naïve public may ask for other action.

"Revolutionary":

JOSEPH C. DOANE, M.D.
Medical Director
The Jewish Hospital
Philadelphia


Dr. Doane

PROGRESS can never be made unless somebody dreams of improvement. In the case of Dr. Bernheim's article there are many who will believe that his dream is a veritable nightmare. To say the least, his suggestion is revolutionary, and he cannot expect to receive the accolades of the surgeons generally as the most popular writer of 1947. On the other hand, there is much truth in Dr. Bernheim's premise.

Hospitals are lax in being certain that only surgeons who are experienced and capable are permitted to use the scalpel. Too many run on the concession basis—get a patient, we will give you a room and operating room privileges. There will be many who will resent the classification of the practice of medicine and surgery as a business, and yet there are others who believe that surgical charges are too high.

The degree of Doctor of Medicine certainly is but the beginning and only when the public realizes that such a degree does not qualify a physician for specialty practice will the inexperienced give way to the experienced in matters which concern life and death. In every profession there are those who desecrate the ethics and traditions of their calling. The lawyer, the social worker and even the clergyman have been found to have feet of clay.

It is a little surprising to read from the pen of a founder of the Amercan College of Surgeons, and the American Board of Surgery, that he dismisses the splendid work which these two bodies have performed in raising standards with a wave of the hand.

It would no doubt be ideal for hospitals generally to have full time adequately paid staffs. This hardly seems practicable, particularly when one considers that the great majority of such institutions are in suburban or rural districts and have fewer than 100 beds. There are many who will agree that the care of service patients in the hospital is not an adequate *quid pro quo* for an expensive hospital plan. Perhaps the day may come when physicians will expect to pay a fee for the use of the operating rooms, just as does the patient, and in the minds of many this would not be an unfair system. All in all, it can be said that physicians rightfully will resent aspersions as to the integrity of the whole group because a few are dishonest, and hospitals may be set to thinking as to whether they are performing their full obligation to the public by guaranteeing skilled and scientific medical and surgical care to every patient admitted.

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desires, our own way of life. Not maliciously but through force of habit. We doctors were always a group apart and society is much to blame. It puts us on a pedestal. We came to like it and, naturally, do not relish the idea of getting off of it. Who would?

Yet the time has come for us to step down and it would be nice if we'd do it graciously. If we put our minds to it we could do a much better job for our charges than we have done, meanwhile correcting many evils and improving our own status. I am not so fatuous as to believe that taking surgeons completely out of private practice and attaching them to hospitals or groups on a full time salaried basis would solve all difficulties—but it would go a long way and there would be advantages indirect as well as direct. Such, for example, as effecting a better distribution of doctors.

Under no system will the human equation ever be eliminated. Therefore we shall always have some unnecessary operations, some ill-considered ones—in short, too many. But, in the nature of things, if surgeons had only to do the work in hand, if they could take the purely objective view, if they had nothing whatsoever to do with the money part of their work, unnecessary, ill-considered operations would be held to the minimum. It would also naturally follow that surgeons would do only that work for which they were qualified. You'd see little or nothing of the present day "covering of the surgical waterfront" so many surgeons indulge in, too often with mediocre or worse results.

I take it you realize that fewer men would be required to do the nation's surgery. I take it, too, that you realize the enormous increase in revenue accruing to hospitals from the system, also the integrating of some standardization of fees—so desirable and so long delayed—all commensurate with good pay for doctors, probably more than they are making now—in the average. The huge incomes of big name surgeons you read about would be a thing of the past, but I see only good coming from that.

I know what you are saying. This is all wrong. The whole thesis is a mistake. Hospitals aren't supposed to make money and have no right to accept fees from patients. That is the prerogative of the private doctor, and so it is, if he puts up his own hospital and runs it himself, paying all expenses. He has not been doing that all through the years. He's been having society do it for him, giving in return his services free to the hospital's poor or ward patients.

Only Society Doesn't Know

And what a glorious racket that's been! The only one that doesn't know that is society. Far from being irksome this free work of hospitals—so-called services—is as the breath of life to doctors. That's how they learn and become proficient and that is why there is a constant, often bitter struggle going on for those privileges. I have known men who would have sold their souls literally for a hospital service.

So all through the years private doctors have been in the delightful position of having society put up and equip and run with constantly mounting deficits places wherein they transact their private business—on the mistaken theory that they pay for it by caring for the "services." Little wonder they don't want a change. It's no small job to put up and run your own place of business and most doctors wouldn't know how, let alone the little matter of raising capital. Yet it can be done and is being done successfully by a growing number of private institutions and some that are not private.

The Mayo Clinic, the Lahey Clinic, Guthrie's are examples of the first, and all the great medical schools

with hospital attached that are in process of going on full time are examples of the second. All their doctors are on salary and their hospitals take all fees. So the thesis is not a mistake.

I should not think metropolitan hospitals would ever be completely self supporting but they would take a long step toward it under the system envisaged. Society would always have to pay for its own poor — and in full, not niggardly and in part as we so frequently see it now. There is no more reason for non-municipal hospitals' doing society's work for nothing and doctors' giving their services free than there is for the merchant's giving his wares free. We've just been following custom and custom has been wrong.

It will be obvious that charges made by hospitals and salaries paid their staffs will depend on many different factors — location, clientele, size and such — and so each one will have to work out its own economy. Some hospitals will need more surgeons than others and some will need more specialists. Not every one will be able to afford or would need a brain surgeon, a genito-urinary surgeon, and circumstances occasionally may make it necessary for men to cover several fields but, generally speaking, there should be little of this.

Look at Private Clinics

To those who would have it that patients wouldn't go into hospitals manned exclusively by full time salaried surgeons; you couldn't get the best men to take such jobs; initiative would be stifled; there would be no free choice of doctor, I should ask them to look again at the great private clinics. They seem to have none of these difficulties. Even if it were said that the system wouldn't work in metropolitan centers I wouldn't agree. Staff doctors would have their offices in their respective hospitals but there is no reason why the same hospitals couldn't maintain offices in regular office buildings as well, for strategic reasons and to favor the many patients, especially children, who are made nervous at going to a hospital for any purpose. It's all a matter of executives working out details in the most sensible and practical manner.

Plight Too Well Known

I have not discussed the plight of the people under present conditions for the simple reason that it's too well known—and known to be bad. They do not have any real choice of doctor, certainly not of surgeons — only those who pay have that and they are the great minority. So why talk about it so much? Few people know who is or is not a good or proper surgeon and not too many physicians do. How can they, since most of them rarely go near an operating room and couldn't judge if they did? Surgery is too big and involved and technical for that. Friendship and money arrangements assume prominence in referring cases, with the patient having little to say. Under the new system patients and doctors alike would choose only the hospital or clinic, the rest being left up to the institution's chief of staff. That is the way it is done now on the services and few will say that it isn't good — or that it doesn't shed credit on the profession.

This brings up the next question, which is that there are good hospitals and poor ones, also good doctors and bad ones in them. Just paying a doctor differently isn't going to take the badness out if he's got it in him, but if he is a staff man pure and simple and has to conform to regulations it stands to reason the chance of controlling him is much better than it otherwise would be. It is a trite saying that water seeks its own level and so do men. I can see that hospitals of questionable character would kick back money to the physicians who send them work and it doesn't take much imagination to see other reprehensible things taking place, but, on the other hand, supervision and control would be considerably easier.

Dislike the Rugged Life

The last point to be made is distribution of doctors, which is a by-product, as it were, but by no means unimportant. If surgeons were taken out of private practice a lot of men would have to go out of business or migrate, certainly from the metropolitan centers where, if I am any judge, less than half of those now practicing are really needed. The latter men, the occasional operators or those who do a bit more and have other interests, like insurance or contract work, would find themselves out in the cold. Many of them are capable men who are content to make but a simple living so long as they can remain in the cities. They dislike the harder work and more rugged life in the land out yonder—as do their wives—and the greater opportunities and the people's needs leave them cold.

The medical profession has found no way to deal with this serious problem but I think this new system will settle it automatically, in part if not in toto. Once a man gets to operating he rarely gives it up. It gets in his blood. He likes the excitement of it, to say nothing of its other interesting features. It would be my guess that if proper hospital and other facilities were provided and suitable living and financial arrangements were made, the trek of good surgeons to outlying districts would not be long delayed.

This alone would be justification for integrating the system suggested. Linked with the other advantages I find it hard to see convincing objections—and time is of the essence.

TWO STORY 50 BED ACUTE GENERAL HOSPITAL

The 50 Bed Hospital—Its Planning and Costs

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THE passage of the Hospital Survey and Construction Act, authorizing a nationwide hospital program, has stimulated intense community interest in the provision of adequate hospital facilities. This interest is not limited to those in the hospital and medical professions. Public spirited civic leaders and organizations have accepted their responsibility. Working together all over the country, these groups are developing plans for the hospitals and health centers necessary to safeguard the common health.

Teamwork and leadership of this nature are essential to the success of any community program. Hospitals, however, are complex institutions, expensive to build and maintain. To undertake the planning and construction of one without authoritative advice and guidance is almost as foolhardy as navigating a ship without a compass. In the larger urban communities competent hospital administrators, consultants and architects are usually available to contribute to the overall planning. Unfortunately, in smaller communities such specialized services do not often exist.

These small communities need not suffer too much from this lack of consultative service inasmuch as there are groups to which they can turn for help. The U. S. Public Health Service has established a Division of Hospital Facilities which gives assistance to states, groups and individuals on all matters pertaining to hospital construction and management. This assistance is available from the various district offices of the service, through the agencies in each state charged with the responsibility for health and hospital care.

As an initial aid to those smaller communities without expert guidance, the following information on the 50 bed hospital has been prepared in the hope that it will be of value in planning for a high standard of patient care and for efficient and economical operation.

Measuring Community Needs

Probably the first step in community planning is the establishment of a local hospital committee. This committee should be representative of the community. It should include the best minds of the medical, nursing, dental, pharmaceutical, religious, legal and architectural professions. It should also include local government officials as well as representatives from farm, labor, business, welfare, press and women's groups. From this advisory group can be selected small working committees.

Valuable information on the functioning of this committee can be obtained from the state hospital association and from the Bacon Library of the American Hospital Association. Of particular interest to such a committee is the American Hospital Association booklet, "Measuring Your Community for a Hospital" (15c). Another publication to be studied is "The Small Community Hospital" by Southmayd and Smith, published by the Commonwealth Fund, New York City ($2). This presents excellent material for guidance in the formation of standards for the governing board and the medical staff and in other matters essential to a well run hospital.

No local committee should overlook the agency designated in its state to carry out the hospital program under the Hospital Survey and Construction Act. One of the most important features of this legislation is the requirement that each state appoint an official agency to conduct an inventory of existing hospitals and health facilities. From this survey it

will develop a statewide construction program, designed to assist in providing adequate hospital facilities for everyone.

Any community hospital plan should be coordinated with the state program even though it may not benefit from financial provisions of the act. This should be done as early as possible through the state health department or whatever agency is responsible for the survey.

Estimating Needed Beds

Information in this article is not intended to recommend a 50 bed hospital for a particular community or population group. Such need can be determined only by intensive study of local factors. Local pride, sentiment and emotion are not sufficient reasons for building a hospital.

To estimate the number of beds required to serve a community adequately requires knowledge of many conditions locally and in surrounding areas.

In general, the figure of 4.5 beds per thousand population has been established as necessary to meet a community's hospital needs. However, it is neither necessary nor desirable to follow this ratio exactly in every community for several reasons. In metropolitan areas, the ideal number of beds would probably be more than 5 per thousand whereas 2.5 per thousand probably would suffice for more sparsely settled sections of the country.

This difference in ratio does not imply a difference in hospital requirements for rural and urban people. What it means is an adjustment of bed concentration, depending upon the services the hospital is able to render. The large metropolitan hospitals offer more specialized medical services and more nearly complete facilities and, as a result, they serve patients from less populated centers where the hospitals are limited in the types of care they can give. Naturally their bed ratio must be higher if they are to take care of patients referred to them from outlying sections.

The size of the areas to be served as well as the density of population will determine what compromise must be made between the ideal number of beds and the number that is practical to achieve and maintain. In initial construction, it is far better to provide a minimum of beds, with provision for future expansion as the factors limiting hospitalization are overcome, than to attempt a project beyond the community's financial resources.

Wherever possible, a competent hospital consultant should be called in to aid in determining the need for beds. Not only must area and population be considered, but sickness, accident and death rates should be analyzed. This task is not an easy one for the layman. Records of actual sickness rates usually are not available as most illnesses cause only temporary disability, are not communicable and consequently are not reported.

One of the most important factors in planning a small hospital and in estimating the number of beds is a coordination of hospital services. The concept of such coordination involves two basic principles which are vital to the provision of good hospital care on a broad scale. These are, first, the orderly flow of professional personnel, special services and educational opportunities from the larger hospitals to the smaller institutions and, second, the flow of patients, specimens and records from the smaller to the larger hospitals.

On a regional basis, there are four links in this chain. The first is the small community clinic in isolated areas. The second is the rural or community hospital, usually a 50 bed or somewhat larger institution. The third is the district hospital and the fourth, the medical center or university teaching hospital.

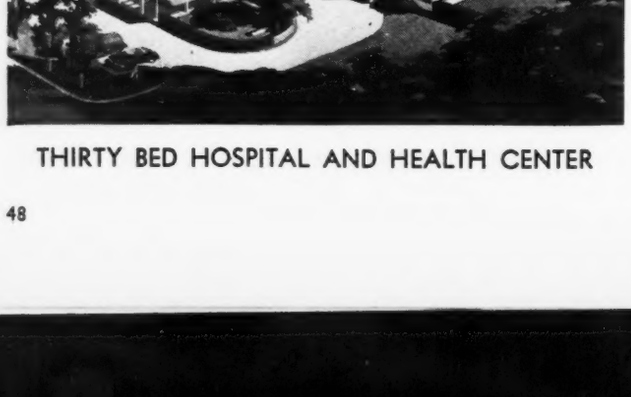
Obviously the community which needs a hospital should seek affiliation in such a chain. The quality of the services which it renders can be materially raised when more consultants, better equipment and more nearly complete clinical facilities are available. In addition, administrative guidance and advice from the larger, better staffed institution will result in economy, efficiency and other benefits to the small hospital and its patients as well as to the community. Only through such an arrangement can adequate hospital care be assured when facilities, staff, personnel and equipment are limited.

Planning the Building

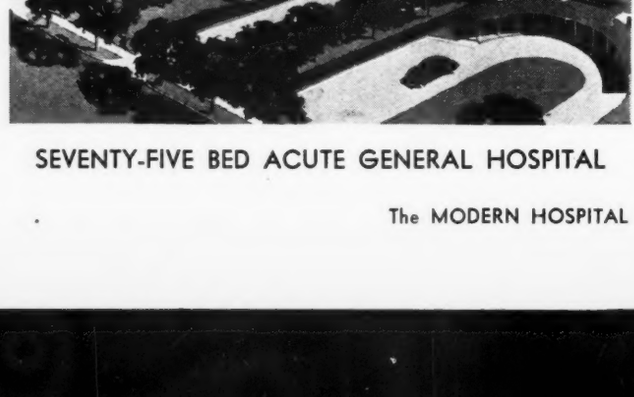
A competent architect, one preferably experienced in hospital design, should be employed from the beginning. When study and planning have indicated the need for a 40 to 60 bed hospital, the following practical aspects of building and operation should be considered.

The public is likely to think of a hospital as simply a house or building with beds. This is far from the truth. A hospital, however small, is a complex institution, designed as a tool for the physician in order that he may better serve his patients. To a marked degree the efficiency of his services is affected by the planning, organization and management of the hospital.

When planning a hospital the community's first thought is usually the site. A hospital site should be selected because it is suitable for present use and not because some philanthropic person donated the



THIRTY BED HOSPITAL AND HEALTH CENTER



SEVENTY-FIVE BED ACUTE GENERAL HOSPITAL

land. Moreover, this site must be adequate for future expansion. The minimum sized plot should permit doubling the original building without crowding or encroachment. Other features to be considered are accessibility by car or public transportation, freedom from noise and nuisances, proper exposure and availability of public utilities.

Just as impractical as a poor site is the existing house or building which has been given to a community with the view that it be turned into a hospital. Usually this proves to be an expensive venture. Upkeep is higher. Efficiency, safety and sanitation are more difficult to achieve. Remodeling is constant, expensive and never satisfactory. In the end it is almost always more practical to start from the beginning and construct a building for the function it will serve.

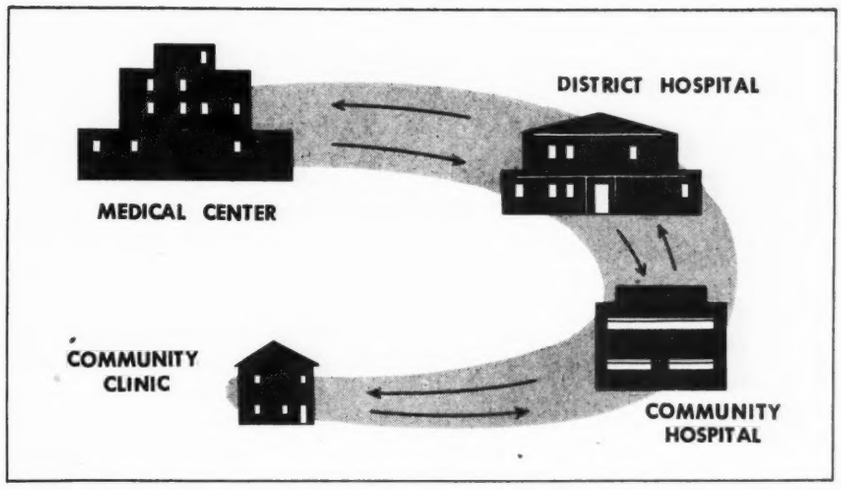
The actual design of the 40 to 60 bed hospital will vary with locality, site, material and, of course, services to be rendered. Excellent examples are shown in the book, "The Modern Small Community Hospital and Health Center," published by the Modern Hospital Publishing Company ($7.50). This volume is a compilation of prize winning designs of 40 to 60 bed hospitals; it also contains sound advice on community planning.

Large scale room details of departments within the small hospital are available from reprints of material developed by the Division of Hospital Facilities of the U. S. Public Health Service, along with equipment and supply lists.

It must be emphasized that any plan must be adapted to local needs and services.

Space requirements for the 50 bed hospital total from 550 to 600 square feet per bed. This provides the 80 square feet which the bed occupies and the necessary space for administration, offices, storage, kitchen, utility rooms, laboratory and other essential areas.

For economy and flexibility, room distribution is best provided in one bed, two bed and four bed rooms. Two nursing units of 25 beds each are more efficiently staffed with limited personnel if they are on the same floor. Two rooms in each nursing unit should be planned for isolation but should be adaptable to general purposes when not required for isolation. One of these should be planned for temporary care of mental patients. Maternity service should be completely separated from other activities.



Flow chart showing movement of professional personnel, special services and educational opportunities from large to small hospitals, and flow of patients, specimens and records from small to large institutions.

One major and one minor operating room will suffice. The kitchen may be located in the basement, but not more than a third below ground level. Needless to say, in designing the building, fire and sanitary regulations must be complied with. The state health department can give sound information on these phases.

Optional Facilities

Outpatient Department. Few community hospitals can adequately discharge their full responsibility without proper facilities for outpatient services, unless such services are available through other sources. This department should be located, preferably, on the first floor level for easy access by ambulatory patients and to reduce traffic within the hospital. The laboratory, x-ray, pharmacy, emergency room and ambulance entry, records and similar facilities should be located so as to serve both hospital and outpatient needs without undue inconvenience. Adequate space for waiting rooms, examination and clinic rooms and other necessary areas in the outpatient department will require approximately 40 square feet per daily patient visit.

Health Center. Public health activities are usually concerned with the health of the masses *i.e.* preventive aspects, whereas the hospital and the private practitioner deal primarily with the individual, or curative medicine. To attempt to separate preventive and curative measures is to weaken the value of both. Adding offices for the public health staff to the hospital makes possible the common use of clinic space, laboratory and other space and services. Each activity becomes more familiar with problems of the other. Thus, each can more efficiently discharge its responsibilities to the community, and at a distinct financial saving to the taxpayer.

Offices for Private Physicians and Dentists. Physicians and dentists apparently are finding that group practice may provide better patient care and at the same time increases their own efficiency. Adding to the hospital offices for group practice or for the individual practitioner often makes for a highly desirable continuity of medical care. Inasmuch as the success of the hospital and, in fact, of the entire community health program depends upon the ability and interest of these practitioners, the provision of office facilities at reasonable rentals is a practical measure that the community should consider.

School of Nursing. While the limited facilities of the small hospital may be used for some types of affiliated work with the larger accredited nursing schools, the smaller institution cannot offer sufficient teaching material for a satisfactory school. Instead, it should limit its instruction to the training of employes as practical nurses or nurse's aides.

Personnel Quarters. Because of personal preferences and adminis-

trative problems, the trend today is definitely away from providing living quarters for any hospital personnel except in isolated locations.

Costs of Construction

The variation in labor and material costs in different localities makes it impossible to quote figures that would apply to a specific community. In reply to a questionnaire by the American Hospital Association early in 1946, the average total cost as estimated by contractors and architects from all sections of the country was $8800 per bed. This may be roughly divided into about one half for labor and one half for materials. It includes $1500 to $2000 per bed for fixed and movable equipment and furnishings, and supplies necessary to begin actual operation of the hospital.

Even the foregoing prices have probably increased in the average community. Accurate construction cost figures for a particular area can be obtained by having a local contractor estimate on the basis of from 550 to 600 square feet per bed. To the costs of ordinary building in the area must be added about 20 per cent for the unusually expensive methods, materials and equipment necessary in hospital construction.

Financial Assistance in Construction. The Hospital Survey and Construction Act provides for federal assistance in the construction of hospitals and health facilities. This assistance is available to any nonprofit organization on the basis of one third federal funds when matched by two thirds nonfederal funds. However, any hospital to be assisted with federal funds must be included in an overall state program designed to supply facilities where they are most needed.

Operating Costs

In general, annual operating costs total about one third the cost of construction of the institution, or from $2000 to $4000 per bed.

Occupied Beds. The average number of beds occupied by patients is usually directly related to the size of the hospital, *i.e.* the smaller the number of beds the smaller the percentage occupied. In the United States from 1940 to 1945 the actual occupancy of beds in hospitals of from 40 to 60 beds varied from 57 per cent to 68 per cent.

This occupancy rate directly affects the operating income and therefore the quality and quantity of services the institution can render.

Personnel. Salaries and wages account for not less than 50 or 60 per cent of the annual cost. The average 50 bed hospital will require at least 35 to 50 employes if an adequate standard of care is to be given. The staff would include the director, nurses, aides, clerical, technical, maintenance and other personnel, with an average wage of $1500 or a yearly total of from $50,000 to $75,000.

Supplies and Equipment. The annual costs of supplies in 50 bed hospitals will average about $500 per bed or a total of $25,000. Food constitutes somewhat less than half of this cost if only patients' food is included. Meals for a daily average of 30 patients at 75 cents a day each would total $8200 per year. Equipment costs will average about $75 per bed or $3500 a year.

Laundry. Whether the hospital operates its own laundry (the advisability of which may be open to question) or uses commercial facilities, the cost will be about 5 cents a pound. Patients average 12 pounds of laundry daily with an annual total for 30 patients of 131,000 pounds, costing $6500.

Maintenance. Light, heat, maintenance and repairs would require about $100 per bed each year, a total of $5000. Insurance, legal and miscellaneous items would probably total a similar amount.

Taking all these expenses into consideration, a 50 bed hospital will cost not less than $100,000 a year to operate. For 30 patients this would mean a daily average cost of about $10. Of course, these figures will vary with local salary scales and other costs. The daily cost per patient naturally will be reduced if the number of occupied beds exceeds the 60 per cent mentioned.

Small hospitals attempting to reduce operating costs are often faced with the temptation of reducing quantity or quality of personnel. This is poor economy, as the standard of care of patients is quite likely to suffer. Good hospitals are expensive in dollars and cannot be compared with business, which is operated for profit and not as a public service. Poor hospitals may cost less money to operate but are more expensive in terms of human life.

Only after deliberate and thorough study of all factors involved in hospital need, planning, staffing, maintenance and operation should community funds be committed to so expensive and involved an undertaking as the building of a hospital.

Education for the Staff

SEVEN outstanding physicians from various sections of the country led the discussions of the "First Annual Postgraduate Assembly" sponsored by the staff of the San Diego County General Hospital, San Diego, Calif. A total of 297 physicians registered for the three day medical seminar held October 6, 7 and 8. Representatives came from five counties in California and from two other states. The assembly was a success, and plans are now being discussed for the second assembly to be held in the fall of 1948.

The postgraduate assembly was financed by the staff trust fund. In July 1946 the county board of supervisors, upon recommendation of the medical staff, instructed the county hospital to render staff bills to those patients who were able to pay for the services of the voluntary staff physicians. From July 1946 to June 1947 a total of approximately $6300 was collected and deposited in the staff trust fund, which is designated to be used for educational purposes.

Sectional meetings were held at the county hospital each morning. Cases of general interest were presented and discussed in the following sections: surgery, obstetrics and gynecology, urology, orthopedic surgery, medicine and pediatrics. General sessions were held in the auditorium of the U. S. Naval Hospital each afternoon.

Dr. John M. Rumsey, chairman of the staff, appointed a committee of six attending physicians to plan and program the assembly. The administration took the responsibility of modifying certain wards for lecture purposes, providing chairs, blackboards, movie projectors and screens for each of the six sectional meetings. —JOHN W. DOUBENMIER, *assistant superintendent, San Diego County General Hospital, San Diego, Calif.*

MINIMUM STANDARDS for Chronic Disease Hospitals of 150 Beds and Over

A. P. MERRILL, M.D.

Superintendent, St. Barnabas Hospital for Chronic Diseases, New York City

NUMEROUS inquiries from all over the country regarding proper facilities, physical and medical, for the adequate care of chronic disease patients indicate the widespread interest in this important subject. Many voluntary hospitals, as well as government programs, contemplate the establishment of facilities for the care of chronic disease patients.

A year ago, the American College of Surgeons asked me to submit certain suggestions regarding minimum standards for chronic disease institutions. This and succeeding articles on the subject are an adaptation and modification of the material prepared at that time. Until now, there have been no comprehensive standards developed specifically for chronic disease hospitals as specialized institutions.

It is difficult to delineate sharply problems of institutional care as they relate to the healthy aged, the infirm aged and the chronically ill. The relations are both subtle and vague.

Application Is Desirable

There is a great deal of thinking and discussion regarding medical care of those in homes for the aged. It seems desirable, wherever possible, to affiliate homes for the aged with either a general or a chronic disease hospital. At St. Barnabas Hospital, New York City, for example, when patients become well enough so that continued care in the hospital section is neither necessary nor justifiable, we transfer them to the Braker Memorial Home. Conversely, when patients or Braker Home guests become infirm or chronically incapacitated or ill—as most of them do—they have immediate access to the facilities of our chronic disease hospital. Moreover, most of the Braker people attend our clinics and other special departments for ambulatory care while residing in the Braker Home.

It is my belief that this relationship among the various classes of chronically ill patients—that is, acutely ill, subacutely ill, those requiring merely domiciliary care and, further, those progressing to complete recovery—should be emphasized. Our Braker Home is more than just a home for the healthy aged. Like all other homes for the aged, it has a large number of infirm aged. Moreover, even those who are sometimes classified as healthy aged carry around with them many chronic, physical and emotional, as well as mental, conditions that make them periodically susceptible to complete breakdown or at least the necessity for continual medical supervision even though they are ambulatory.

In any program for the total care of the chronically ill patient, there should be facilities such as are projected by our Braker Home, where borderline cases can be cared for adequately. Another way of doing the same thing is by a home care program such as was recently established on an experimental basis at Montefiore Hospital, New York City.

The minimum standards set forth here are for a chronic disease hospital of 150 beds or more. Throughout, references to facilities and organization at St. Barnabas Hospital are used to illustrate various standards; it is not intended to imply that these details must be duplicated in other institutions.

PHYSICAL PLANT. A modern physical plant is essential, as it is with general hospitals, free from hazards and properly equipped for the comfort and scientific care of patients. Special deviations, however, are desirable for the chronic disease hospital.

It is important, for example, that chronic disease institutions be designed to provide sufficient solariums, balconies, gardens and grounds, allowing long term patients maximum sunlight, fresh air and exercise in open air. Moreover, special consideration also should be given to numerous elevators of large capacity and wide doors so wheelchair patients can be moved freely from floor to floor.

In addition, wide doors should be provided for all lavatories and other doorway entrances. Similarly, railings are necessary in lavatories, bathrooms, elevators and elsewhere so that feeble patients can have railing support. Wide corridors are essential also, allowing for placement of wheelchairs throughout the institution in the halls or other designated locations. Our experience indicates that as many as 45 per cent of patients may use wheelchairs, partially or entirely; 35 per cent or more of patients may be bedridden, and 20 per cent, ambulatory. Problems of nursing and medical care are emphasized further by the fact that 34 per cent or more of patients may be incontinent and as many as 20 per cent unable to feed themselves.

Physical facilities for proper dietary service should also receive particular attention. In our institution 80 per cent of our patients are served at their bedside from floor pantries, but provision is made for an ample ambulatory dining room, as well as a wheelchair dining room on the main

This is the first in a series of articles by Dr. Merrill describing minimum standards for chronic disease hospitals. The second article in the series will appear next month.—Ed.

floor, which ordinarily serves about 70 patients, or approximately 20 per cent of the 350 patients in the hospital section of the institution.

To provide for diversional and recreational activities at St. Barnabas Hospital for Chronic Diseases, the institution is situated on 10 acres of landscaped gardens and grounds. Special provision also has been made for a large recreational hall as part of the main building; this hall will comfortably seat more than 200 persons. Two movies and one professional entertainment are given weekly for the benefit of ambulatory and wheelchair patients.

In addition, every bedside is connected with a radio headset and radio loud-speakers are located also in all solariums. A central control room allows for the reception of two continuous broadcasting channels and makes provision for broadcasting throughout the hospital of chapel services and special entertainments from the recreation hall.

The spiritual welfare of patients deserves special attention also and is provided for by a beautiful chapel equipped with pipe organ and broadcasting facilities. Space is available in the chapel for both wheelchair and ambulatory patients. A part time chaplain gives bedside ministrations and holds two regular weekly chapel services. Facilities of the nature described are especially important for institutions accepting chronic disease patients.

It is desirable that chronic disease hospitals be located away from smoke and dirt in centers of cities, perhaps in suburban or outlying areas, but never sufficiently removed so as to isolate the institution socially and medically or make access difficult for relatives of patients or for deliveries of supplies.

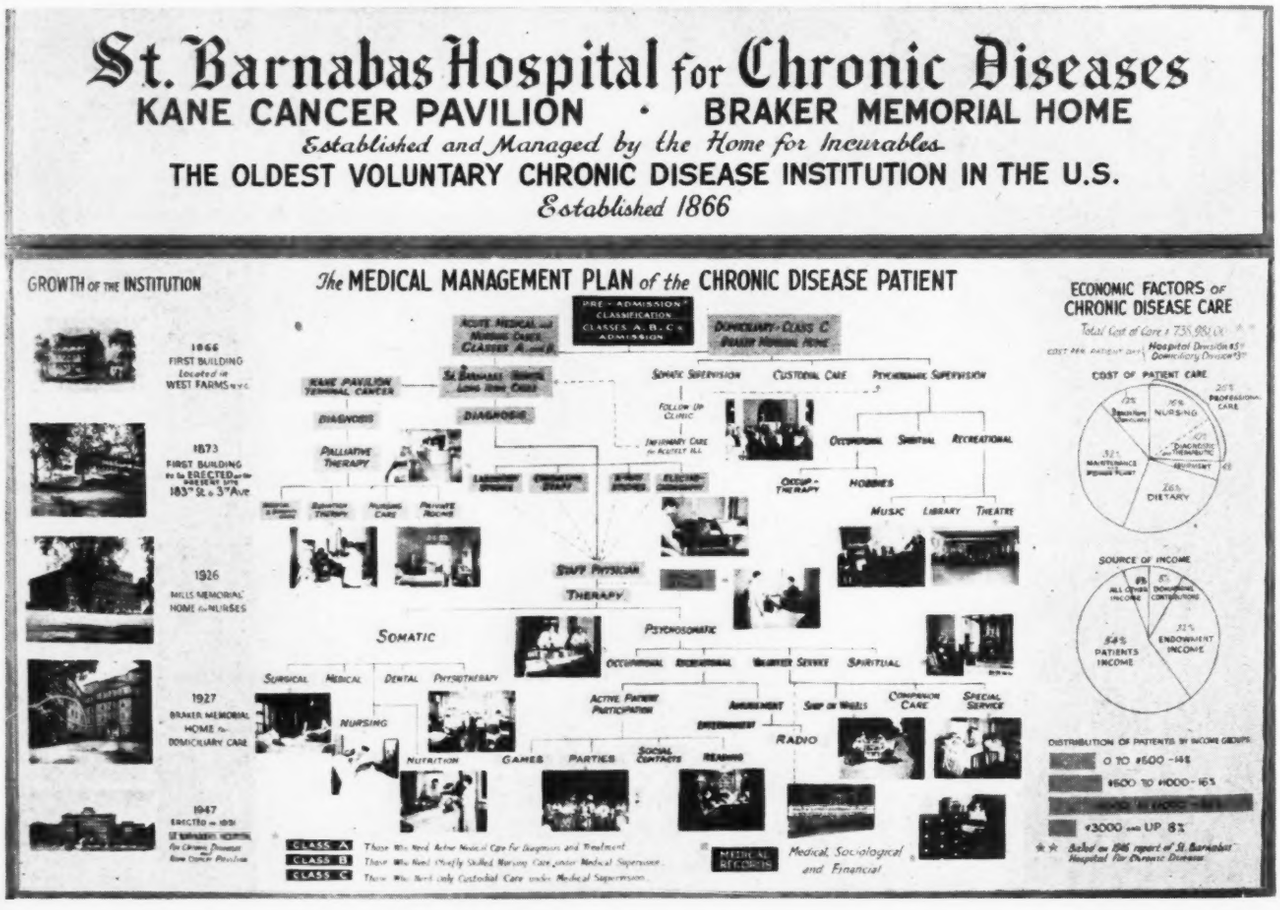
Special consideration in building construction is required in view of the peculiar medical and nursing problems characteristic of chronic disease patients. In general, long term patients can be divided into three groups as follows:

1. Those requiring a large amount of intensive medical and nursing care.
2. Those requiring chiefly skilled nursing care under regular supervision by physicians.
3. Those requiring custodial or domiciliary care under medical and nursing supervision, perhaps of an ambulatory or clinic type of service only.

Patients admitted in class 1 may improve over the months so that they progress logically to class 3. However, a sudden heart attack or recurrence of a "stroke" may throw the patients again into class 1. Therefore, physical facilities should be available whereby patients can be interchanged conveniently among these three types of accommodations so that medical and nursing care will be appropriate to the physical condition. In other words, accommodations should be available which provide complete medical and nursing care as in a general hospital, when required, or other less intensive facilities, as occasion warrants.

Secondary facilities similar to those of the general hospital should be available also but require less supervision, particularly on the part of the medical staff. Finally, accommodations may be provided in a separate institution for custodial care; patients of this type are able to come to a clinic or may be transferred temporarily to an infirmary.

The situation described prevails at our own institution. For example,



the infirmaries of our main building provide facilities for chronically ill patients who are sickest; other sections of the hospital, particularly the larger wards, are available for patients of class 2 type, and, finally, the Braker Memorial Home, a separate institution, is available for patients or guests requiring custodial care only. The latter institution might be regarded essentially as an "old people's home," or a domiciliary institution that is closely related to the medical management plan of the entire hospital.

It Takes TWO to Make a Good Record Department

—*A well trained librarian and an understanding administrator*

IVY ROSE HUBERT, R.R.L.

Formerly, Editor in Chief
Journal, American Association
of Medical Record Librarians

ANY good working relationship among hospital professional groups requires a nice balance between the ideal and the practical. It requires mutual understanding and acceptance of responsibilities, of functions, of the aims advocated by each profession and of the shortcomings of each group.

In regard to the record department, the hospital administrator has a mental concept of his responsibilities, his functions and privileges and the quantity and caliber of service he should receive from the department. The medical record librarian, too, has a mental concept of her responsibilities, her functions and privileges and the kind and caliber of service she should render—and to whom.

If the hospital administrator and the medical record librarian cannot make reasonable and mutual concessions to bring their two concepts into line without damage to either group, then both are in for a period of stress and strain greater than has gone before.

The beginnings of such a period are in evidence. Position changes among medical record librarians have reached an all time high. Each time one medical record librarian resigns a whole series of changes takes place as other librarians shift to fill a succession of vacancies. This is a costly and wasteful way to make progress, but medical record librarians are finding it expedient.

Recently, some of the all too few record training schools available have had to close their doors because they lack qualified recruits. Hospitals that have in-service training programs now find it difficult to get personnel willing to start at the bottom of the ladder and work up slowly.

Must Regain Lost Ground

For lack of sufficient personnel, or for lack of any experienced personnel at all, many hospitals see their medical record departments deteriorating rapidly. Gaining back the lost ground is going to be difficult and expensive. It will be a worthwhile expenditure, though, if in the rebuilding process the hospital administrator and the medical record librarian clearly understand what each expects of the other because only with such understanding can come a record service better than before.

Both the administrator and the librarian admit that even the best medical records today are far from perfect, and the variation in the quality of records in hospitals throughout the country is no credit to medical record librarians as a whole or to hospitals. Both know, too, that a superior technical service, such as medical records, cannot be made available for every hospital unless there is a steady supply of trained personnel to do the work and to improve its quality. A steady supply of personnel means that candidates for training must be recruited. They cannot be recruited if the field is not attractive vocationally and if too few hospitals make the right kind of training available.

The young woman who has the intelligence, education, skills and initiative the hospital administrator expects of the medical record librarian can today carve herself a better career in other fields in which there are more opportunities for administrative responsibility and advancement and more recognition of effort expended.

This boils down to the fact that hospital medical record service is not measuring up to the expectations of administrators and will never do so until there are enough trained people

Presented at the New Jersey Hospital Association meeting, 1947.

to do the work. There are not enough trained people available because the hospital has not made the vocation attractive to well qualified candidates.

Ergo, the hospital administrator should make the work more attractive, then more candidates will come into the field for training and then hospital record service will improve.

To make the vocation attractive there must be professional status for the medical record librarian, and for all record personnel an opportunity for good in-service training and gradual advancement. The record department itself must be adequately staffed, well equipped, well located and physically comfortable. Salaries should be commensurate with training, experience and responsibility and should compare favorably with those paid other technical personnel in the hospital and in the region.

Puts the Cart Before the Horse

Hospital administrators are perfectly right when they say that this is putting the cart before the horse—it is just that. Normally, the producer of service must meet all standards of performance first and then set up standards of what is expected in return. The administrator has a point in saying that medical record librarians should prove themselves thoroughly first and take the initiative in recruitment and training on a large scale before they make demands for ideal working conditions and professional status.

Unfortunately, professional growth is too slow if it follows that course. A young profession must take on more than it can handle and go through a period of imperfect performance or it will make no progress. It must demand more than it deserves to gain anything at all. It must consolidate its gains at intervals and take a definite stand for the future. Most of all it must have sympathetic assistance from the organizations it serves and plans to serve better in the future.

Assistance of the type just mentioned has been forthcoming from hospitals for various other professional groups. Most hospital administrators will agree that the medical record librarians have come far enough now to merit similar support. Until the recent financial grant from the National Foundation for Infantile Paralysis, the American Association of Medical Record Librarians had no major funds for the development of any large scale training program.

The medical record librarian has really gone as far as she can on her own in improving medical records and the quality of record personnel. Only a few hospitals have developed good in-service training programs to take care of their own needs. Only 10 hospitals have taken on the responsiblity of formal training courses for medical record librarians, and fewer than 50 persons are trained in all these schools together each year. The candidates accepted must already have from two to four years of college and several months of business training at their own expense and must pay tuition and outside maintenance during their year of hospital training. The self trained librarian must invest several years of hospital apprenticeship at low pay and long periods of study to achieve her R.R.L.

The institutes sponsored by the American Hospital Association are a splendid innovation but they are also a recent one. Most medical record librarians have pulled themselves up by their own bootstraps—and hospital record service along with them. The rules of professional noblesse oblige certainly permit them to expect from the hospitals they serve some special assistance in carrying on from this point.

The suggestion that the individual hospital, and all hospitals, take a more active part in the building up of the medical record librarian as a professional person and in the training and development of more medical record librarians has come from many sources and has many precedents. The type of financial investment suggested is not uncommon either. Hospitals often make long term investments in a department or subsidize it until it carries on independently. A large expenditure for x-ray service, a surgical wing or new culinary equipment or for training technicians does not pay for itself overnight. Eventually the investment does pay off in greater convenience, less overhead and better service, but the hospital does not expect this to be accomplished immediately.

A small hospital may find it cheaper to hire graduate nurses than to maintain a nursing school but the administrator will keep the school and take the financial loss because the school provides a steadier supply of nursing service in an uncertain labor market. The same philosophy has many applications directly related to medical record service.

For a young profession, medical record librarians have accomplished much so far. There is no reason to believe that they will not go much farther if given a chance to show what they can do under optimum conditions. There is every reason to believe that in the long run any expenditure of administrative effort, time and money to improve the facilities for record service and the professional status of the medical record librarian will pay big dividends.

Aware of Their Weaknesses

Medical record librarians are fully aware of their weaknesses. They will admit them frankly to the administrator and hope that with his assistance they can eliminate them. They know that they feel underpaid and yet have never worked out a feasible plan for the administrator to use in determining salary. The medical record librarian's salary is always determined by private treaty rather than in accordance with any recognizable plan and, inevitably, the bargaining power of the individual has played too great a rôle.

The record librarians know that all their colleagues, even though they are registered medical record librarians, cannot take on equal duties, responsibilities and functions. Therefore, the administrator is justified sometimes in limiting these. They know that the chronic overwork of records is due in part to lack of a clear-cut man hour plan that would convince administrators of the need of assistance. They know that an inefficiently planned or located record room hampers their activities but have worked out no formula to prove this conclusively.

The medical record librarian knows that because of tradition she thinks too much of her charts as medical records and does not see them as hospital records having an overall administrative function.

The medical record librarian also knows, however, that some of her deficiencies stem directly from the position to which she has been assigned in the hospital. This is not a position into which she has been pushed, but a position from which she has been struggling mightily for

twenty years to extricate herself. She sometimes feels that the hospital administrator has not helped her sufficiently to emerge successfully.

The anomalous position goes back to the days when few demands were made upon the hospital record room and the few simple procedures followed could be handled by a record clerk. Since then hospitals have become much more complex and the record room has grown along with them. Trained personnel is needed to keep the record standards abreast of other hospital services.

Record clerks accepted the challenge of new duties and responsibilities and embarked upon a strenuous program of self training. This resulted in the establishment of a national professional organization, under the aegis of the American College of Surgeons. Then came registration examinations, an educational journal, formal training schools, in-service training programs, institutes and the introduction of many new methods for keeping better records. Of late, medical record librarians have paused to take stock of their accomplishments and have evaluated the rewards, too. They see a discrepancy and many are disillusioned with the small personal gains that have been made.

Still Considered "Clerkship"

In the eyes of some administrators the medical record librarian has never emerged from her record clerkship. The administrator who reacts thus is probably justified from his personal experience, because his attitude would make him limit his record department functions to clerical duties easily performed by an untrained clerical person. What is irksome to medical record librarians is that this type of administrator uses the performance of his record clerks as the yardstick for measuring the performance and contribution of the trained medical record librarian.

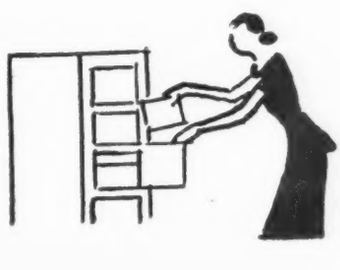
This belittling attitude still appears too frequently in hospital circles. It not only has damaged the professional reputation of the librarian but has alienated her loyalty to the administrator in many hospitals.

Ultimately the medical record librarian hopes to achieve generalized and full acceptance as a professional person in the hospital, with administrative authority to manage the record department as a separate unit; with adequate equipment, space and staff to provide efficient and comprehensive record service, and with a budget sufficiently large to recruit and hold qualified personnel.

Specifically the medical record librarian expects a convenient and healthful place to work, a salary commensurate with her responsibilities and abilities, labor saving devices to reduce the drudgery of clerical routine, enough clerical assistance to keep all work up to date in normal working hours, strong administrative support in enforcing medical record policies and procedures, an opportunity to attend and to have her staff attend professional educational meetings and institutes, thoughtful consideration of her proposals to change old record room procedures or institute new ones, the privilege of attending all hospital conferences where medical record matters are discussed, the courtesy of being consulted beforehand about all proposed changes involving the record department—and frequent opportunity to discuss minor record room problems so they can be solved before they become major ones.

How soon and how fully these professional goals can be achieved by the medical record librarian is a moot question. A lot of them can be accomplished immediately, in individual hospitals, if the librarian and the administrator will only put their heads together and work them out jointly. At the same time, these two will have to analyze the record department thoroughly to find out wherein it can be improved and where it can be changed, if necessary, to provide the administrator with the type of service he feels should be forthcoming.

The hospital administrator who has criticized his record department may find out through such an investigation that much of the onus of poor services lies at his own doorstep. He may find that the librarian cannot organize her work efficiently because she is at the beck and call of too many people and has no authority to refuse unreasonable requests. She may be unable to enforce hospital record regulations because the administrator gives her no support or occasionally overrules her when she tries enforcement. The administrator may find that the record librarian is not familiar with the latest in record technics because he has not made it possible for her to attend educational meetings where she could get information.



Why She Seems Ungrateful

He may find that records go long incomplete because physicians cannot be lured into the isolated, unattractive and uncomfortable record department he has provided. He may find the record librarian resentful of changes because they were thrust upon her as a *fait accompli* decided upon at some conference at which she had no representation. The librarian may appear ungrateful about new equipment because it does not meet her greatest need; a shiny filing cabinet is no substitute for a much needed typewriter. The librarian may appear cool about acquiring a new helper because she has no voice in the selection of the person with whom she has to work closely and perhaps has the responsibility for training her.

The medical record librarian can see *what she stands for* only as other people recognize her position—to oppose or to sustain it. Until her position is fully sustained as she feels it should be, by all hospital administrators, we shall continue to have meetings for discussion of something as basic and elementary as what the medical record librarian and the hospital administrator should expect of each other.

Eventually the medical record librarian will achieve all she expects of the administrator and in the process will render to him all the service he expects of her. How these developments will fall in line chronologically is hard to predict, but most likely the hospital administrator will have to be first with each new development because until he makes a facility available, or surrenders a responsibility, the medical record librarian is powerless to develop or to provide the service that goes with it.

The Public Learns the Reasons

in Minnesota: the Press Presents the Case

PINCHED as all hospitals are between rising costs and stiffening public resistance to high rates, hospitals in Minneapolis and St. Paul recently broke through the barriers of silence and took their case to the public in a dramatic series of newspaper articles.

Any question that the public doesn't care to hear details of hospital economic problems vanished forever in the flood of inquiries and comments the articles provoked from newspaper readers.

"We're finding a lot more understanding attitude on the part of patients and visitors than we ever had before, as a result of these articles," one administrator stated. Another pointed out that one unexpected benefit from the favorable publicity was better knowledge of the hospitals' problems on the part of medical staff members.

As a matter of fact, the articles were prompted not so much by the failure of either public or medical profession to understand the hospital's economic picture as by organized demands on hospitals by the nurses' association. These demands, which had been widely publicized, were centered on increased wages and reduced hours for graduate nurses on hospital staffs. They were not in themselves unreasonable; many hospital people, in the Twin Cities as elsewhere, readily acknowledged that nurses in the main had been overworked and underpaid in past years. Some increases had already been advanced to nurses, however, and the new salaries asked for would have necessitated another sharp increase in hospital rates. Already hospitals had plenty of evidence that people thought their bills were too high.

Out of this impasse the idea for a series of newspaper articles that would "tell all" from the hospital point of view was born.

The *Minneapolis Star* enthusiastically undertook the project, assigning the investigation to David Dreiman, a staff writer, who spent several weeks gathering information from hospitals of all classifications.

As it finally evolved, there were five articles in the series, which appeared on consecutive days in mid-September. Successively, the articles dealt with the general problem of rising costs in hospitals, the plight of the voluntary hospitals, the nursing problem, public hospitals and, finally, the hospital situation from the point of view of the community as a whole.

"How much the public itself is actively interested in the problem has been brought home forcibly," Mr. Dreiman said in his final article, "by the heavy volume of mail and telephone calls regarding this series of articles."

The articles appeared daily on page 1 of the *Star*, under two column headlines. Title of the series was "The Hospital Dilemma."

In working up the series, the *Star* sent questionnaires to voluntary, city, county, state and federal hospitals asking for full information on costs, salaries paid to nurses and other employes and rates charged the public for various types of accommodations. For comparative purposes, current figures were presented along with those of a year ago and six years ago.

The first article in the series dramatically presented an overall view of the hospital's dilemma—the squeeze between rising costs and resistance to high charges. It brought out the surprising fact that many hospitals were reporting empty beds, apparently contrary to the popular belief that all hospitals were still filled to the brim and had waiting lists. It reviewed the demands made by the nurses' association.

In the second article, Mr. Dreiman got down to cases. Here he set forth, with details, the fact that average costs in Minneapolis voluntary hospi-

(*Continued on Page* 58.)

for the High Cost of Illness

Mass Meeting in Cincinnati

AN OPEN meeting to discuss hospital costs and problems was the focal point for a campaign to direct public attention toward the hospital situation in Southwestern Ohio not long ago. Held in Cincinnati, the meeting was sponsored by the southwest district of the Ohio Hospital Association.

In addition to talks which were fully reported in Cincinnati newspapers, the meeting featured exhibits of various items used in hospitals, with price tags showing what they cost in 1941 and what they cost today. Pictures of the exhibits appeared in the newspapers.

Idea for the meeting, and the continued public relations program for hospitals which has followed it, came when a survey of public opinion made by the Cincinnati Blue Cross several months ago indicated complete lack of understanding of hospital problems. Generally, hospitals were taking the blame, in the public mind, for the inflationary trend which was accepted as a matter of course in other businesses.

"I think the charges made by hospitals are outrageous," one leading business man who was queried replied. "While most hospitals may be operating at a loss," he continued, "there must be an element of inefficiency somewhere."

"Hospitals are unquestionably making money," said another. Still another comment was, "We have the feeling that hospitals are taking undue advantage of a bad situation."

Faced with this evidence of woeful public misunderstanding, a committee of the hospital association got busy and planned the meeting which launched a continuing public education effort.

Principal speaker at the meeting was Everett W. Jones, vice president of The Modern Hospital Publishing Company. Mr. Jones made headlines with his prediction that hospitals "are on the verge of closing because of financial difficulties." Striking a note that was picked up immediately by reporters and editorial writers, Mr. Jones pointed out that hospitals have become "essential public services instead of charitable organizations which must go from door to door with hat in hand, trying to get money to continue operations."

Death rates would climb "fantastically," the speaker went on, if closing of hospitals should actually come to pass. Churches or schools could be closed with a lesser effect on community life, it was maintained.

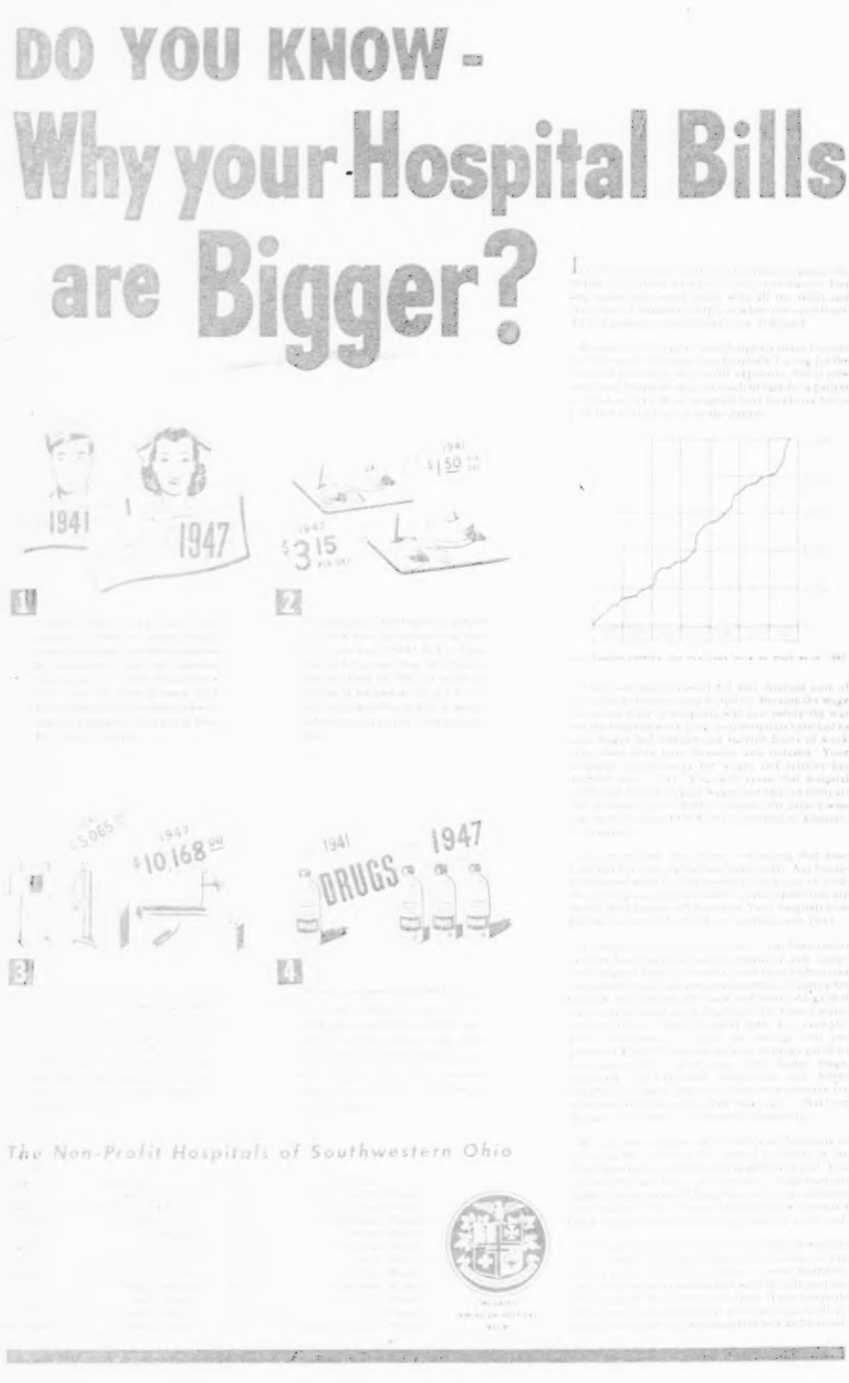
Explaining what had happened to hospital costs, Mr. Jones told the meeting—and, through newspaper reports of his talk, the public—that costs had doubled since 1941. "The public has accepted the idea of paying more for movie tickets and is willing to pay $3.50 for a $1.50 dinner," he said, "so why should it object to paying what hospital service actually costs?

"It takes the very highest type of professional personnel to run a hospital, and it must be paid accordingly," Mr. Jones went on. "Why should my secretary be paid more than my nurse," he asked, "when my nurse saves my life? Why should people be willing to pay $25 a day for a Florida hotel room but resent paying $10 a day for hospital service?" A comparison of hotel and hospital costs followed, emphasizing all the services hospitals must provide over and above hotel services. "The hospital begins where the hotel leaves off," Mr. Jones asserted.

Unless voluntary hospitals can solve their financial difficulties by effecting operating economies and raising rates, they may have to be taken over or subsidized by the federal government, the speaker concluded.

Fully reported in Cincinnati and elsewhere throughout the Southwest Ohio area, the meeting added substantially to public understanding of hospitals, association and Blue Cross officials believe. They have continued the campaign with a series of display advertisements setting forth the hospital picture in further explicit detail. A copy of one of these advertisements is reproduced on page 58.

Cincinnati exhibits showing the increase in cost of various items. Left: The price of gauze sponges has gone up $18.10 in six years. Right: Everett Jones, A.N. McGinniss and Dr. M. F. Steel study the cost of oxygen tents.



Display advertisements like this tell the hospital story in Cincinnati.

tals had jumped from $5.75 a patient day in 1941 to $10 in 1946 and $12.50 today, with costs in some hospitals running as high as $14.75. Salaries, it was explained, took 65 cents of the hospital dollar, compared to 50 cents six years ago. Food costs had soared more than 20 per cent in a single year.

The exact amounts by which hospitals had raised room rates for private, semiprivate and ward accommodations were set forth in an illuminating table. Finally, the article explained the organizational structure of the voluntary hospital, something that hospital people take for granted but few outside the field fully understand. "No dividends are ever paid stockholders," it said. "Some hospitals have endowments from the past; the interest from such funds is generally used for charity cases or other specific purposes."

The third article took up the hypothetical case of a physician whose daughter wanted to be a nurse. Knowing the desperate need for nurses to care for the sick, yet also knowing the lowly economic plight of the nurse, and the "hospital dilemma," the physician argued both sides of the case with himself, for the benefit of the reader. Well known to hospital people, the aspects of the general problem were effectively presented here for public consumption. So was the case of the public hospital—subject of the fourth article in the series. Here, too, the relationship between public and private institutions was brought out.

"The most important person involved in the financial problem facing hospitals and nurses is—*you,*" the final article in the series began. "Minneapolis hospital administrators and general duty nurses agree on this fact: Health of the community outweighs any other single factor."

The greater part of this article was devoted to an explanation of the fact that patients sometimes have to wait for admission to a hospital even at a time when hospitals report empty beds. Departmental and staff lines bringing this situation about were carefully set forth. A check of 11 voluntary hospitals revealed, the *Star* reported, that there were 346 empty beds in hospitals in Minneapolis on the day the series began—out of a 1906 bed total.

Only the Beginning

No solution to the hospitals' or the nurses' dilemma was offered in the concluding article, which simply indicated that one group — hospitals, nurses or public, or possibly all three —would get squeezed further in the future. "Whatever hospital and nursing officials decide won't be an end to the problem," the final paragraph in the series stated. "In all likelihood, it will be only a beginning."

In spite of this dim outlook, however, hospital people in the Twin Cities are enthusiastic about the public relations value of this presentation of their side of the story, in contrast to the "suffer in silence" policy hospitals have usually followed in the past.

What hospitals have done in Minneapolis and St. Paul can be done elsewhere, administrators point out. When newspaper readers all over the country are on the way to an understanding of what hospitals are up against economically today, they say, solution of those economic problems can't possibly be far off.

It's the *System* That Counts
in Simplifying Admission Procedures

J. M. CREWS
Administrator
Methodist Hospital
Memphis, Tenn.

PAPER work might seem a small detail in the whole picture of hospital management, but it can become extremely important if it interferes with normal hospital service instead of helping it along. Delays and errors in making records and duplication of clerical effort can cause confusion, waste and misinformation—or a lack of information that might be highly important at a given time and place.

Let us consider an admission system. It should serve, it seems to me, not only to *admit* the patient and establish the basic records but also to help everyone concerned, from the admittance to discharge of the patient, give the kind of intelligent attention that creates a good impression of the hospital's service in the minds of patient, family or friends who encounter it. A record system can do so to the extent that it furnishes the right information to the right people at the right time.

System Was Unsatisfactory

At Methodist Hospital, Memphis, Tenn., up to a little more than a year ago, our admission system was something less than completely satisfactory. A large number of forms written by both clerks and nurses in many parts of the hospital had accumulated over a period of twenty years. Errors in copying from one form to another were numerous. Delays in writing and distributing information often meant that our supervisors and doctors were without the information necessary to do their jobs.

Card files were used, for instance, by the telephone operators, in the linen room, in the public rack and in the room rack to furnish a ready reference to information about the patient. Information tabs for these files were not made promptly and we did not have adequate control in many of our departments.

It took nine original writings of different records to see each patient through his stay in the hospital. These included an admission record; the heading up of statement and ledger sheets; a temporary patient's record; writing of tabs for card racks at three different points; a permanent patient's record; a discharge slip, and a personal history sheet.

It seemed that we might unify these varied forms. We wanted to simplify the flow of paper work through the different departments. A speed-up of the movement was desired so that all concerned would have information, such as the patient's name, room number, doctor, date of admittance and other necessary details, as quickly as possible. We also thought it was a serious mistake to require our nurses to spend time on clerical work when they were urgently needed for their regular duties.

We decided upon making a thorough study of our procedures and improvement objectives. We wanted a clear picture of exactly what our paper work problem was: each form, its origin, how and where every copy was used, the work involved, delays, inadequacies and so on. This was a task for one experienced in systems work, and we received just the special help we needed in making a complete and detailed system analysis in quick time and without upsetting routine from the Memphis office of a manufacturer of business record systems.

Nothing New Was Added

It is interesting to note that the purpose of the survey was carefully explained to the employes as one of paper work simplification. This enlisted their active support and quieted any fears they might have had that something new was to be added to their jobs.

A flow chart prepared for us showed all the details of our existing routine, indicating the movement of each form, the processing at various points and the correlation among the various departments. Based on all the information assembled, a proposed new system was then laid out on a similar flow chart and new forms were designed.

Our old system had started off with the hand writing of a two part admission record by the room clerk when the patient entered the hospital. The No. 1 copy was sent with the patient to the nurse on the proper floor; the nurse used it for writing a tab for the wall rack and for making up the patient's chart records. This original copy was held in the back of the chart until the patient was discharged; at that time

it was attached to the chart records and forwarded to the room clerk who initiated the discharge procedure. The No. 1 copy and chart records were then forwarded to the record room for typing a temporary patient record. After all pertinent chart information was received, and the patient's record was completed on the No. 1 admission copy, it was entered in the discharge book and filed.

The No. 2 copy of the admission record was used for typing five visible record tabs for our telephone operators, linen room and floor racks, and then for typing the heading for the statement and accounts receivable ledger. At the end of the day, it went to the night clerk who typed the permanent patient file card and entered the admission in the permanent admission book. The record room picked up these copies of the admission form daily there for entry in the admission book and patient's record book, and after a time they were filed in the auditor's office.

The discharge book, admission book and patient's record book are all kept as a service to doctors.

Of the seven visible record tabs, the one in the public room rack was used in our discharge procedure. The room clerk, when notified of the patient's discharge, would pull the tab from the public room rack, stamp it "discharged" and then write a discharge slip which was sent to the telephone operator.

The tab from the public rack was used as authority to clear the linen and room racks.

Our new system enables us to type the two part admission record, nine visible record rack copies, the temporary patient's record, the billing and accounts receivable ledger forms and personal history sheet in one writing, using one set of forms.

Formerly we had used heavy paper tabs for our visible record racks, but we can now use the paper forms themselves which are prepared on the original typing.

We were able to solve the mechanical problems involved in making 14 copies at one time by writing a 9⅞ by 10 inch continuous form, interleaved with continuous one time carbon, on an electric typewriter equipped with a special platen. (See figure 1.) These marginally punched forms enable us to position written entries accurately in the proper spaces on all copies of the closely spaced form, through the automatic alignment and registration of all 14 parts.

FIG. 1

FIG. 1: Typing the 14 part admission record on marginally punched continuous forms. FIG. 2: Nine tabs for visible record racks are included in original forms writing. FIG. 3: Statement and ledger accounts receivable copies are reoperated on bookkeeping machine without rewriting the headings.

Various types of paper stock are used depending upon the purpose for which a copy is intended. For example, a heavier stock is used for the accounts receivable ledger. In addition, the visible record rack forms are perforated so that the unwanted information and extra space can be torn off and the form can be folded to conform to the size of the racks as shown in figure 2.

In making copies for the various visible record files, the maximum visibility is ⅞ inch so the desired information had to show on the first two lines of the form which were exposed.

Our ledger cards had formerly shown the hospital name on the top of the form, but in standardizing all the forms it became necessary to put this on the bottom. To aid in quick identification of the statement by the patient a photograph of the hospital was included as background in the middle of the form.

Our new system when installed reduced the number of original writings from nine to three with the following results as far as our office was concerned:

When the patient is first admitted the 14 part continuous form is typed in one operation on the electric typewriter. The statement and accounts receivable copies are sent to a bookkeeping machine operator for subsequent reoperation as shown in figure 3.

The first admission record copy goes with the patient to the nurse on the proper floor where it is retained in the chart rack until the patient is discharged. It is used in making out the chart records and after the date and time of discharge are noted, the room clerk uses this copy as authority to pull the tab form in the public rack and the room rack. The admission form is then sent to the record room where it is entered in the discharge book and then held in a temporary file until all pertinent chart information has been received. It is finally used as a source of typing the permanent patient's record, after which it is filed.

The duplicate admission form goes to the record room at the end of the day where it is entered in the admission book, then to the room clerk where it is entered in the permanent admission book and placed

in a binder for two months. It is then filed permanently in the auditor's office.

The nine visible record forms have the same information as the preceding forms and are used for identification in the public rack and various floor, telephone and linen room racks.

After pulling the tab copy from the public rack the room clerk writes a six part 4¼ by 3¼ inch discharge slip on an autographic register on continuous forms. The title on each copy is printed in red to help the mail clerk. They provide discharge notice to the telephone operators, linen room, floor supervisor, superintendent and resident surgeon, allowing them all to clear their records promptly.

Thus, under our new system, the only original writing operations in handling the entry and discharge of patients are the typing of the 14 part admission record, the writing of the discharge slips and the preparation of the patient's permanent record.

By cutting down the number of original writings from nine to three, a considerable saving in both clerks' and nurses' time has been effected. The nurses are not required to originate forms at all. The use of three sets of forms instead of six means simplification all along the line.

By typing the 14 essential forms immediately upon entrance of the patient and distributing them at once the information is quickly and accurately made available to all concerned. The one writing on the electric typewriter reduces chances of error caused by hand copying of vital information.

In addition to increasing the efficiency of our own employes, the actual benefits to our patients of this new system are immeasurable, especially in emergency cases where speed is vital.

The discharge system which had been handled before by rubber stamp and scribbled slip was made a precision part of our setup with all concerned able to clear their files promptly.

It will be noted that in setting up this system the number of copies for our visible record files has been increased from seven to nine. As an added advantage of our new system, we are able to provide tab copies for the superintendent and resident surgeon, which they had previously lacked, and an additional copy for the floor nurse—all within our set of 14 forms. One tab writing operation in the old system was eliminated. An accurate census of the hospital is possible at any time by checking the admission records against the room rack copies.

The speed of this system gives us much better control because we know that all information is up to the minute and accurate. As the essential information appears in the same relative position on each form it is quick and easy to read. Our filing systems have become more uniform also.

Some of the savings that resulted after the establishment of this new system are evident in the reduction of the amount of clerical help required. More difficult to determine, but immensely more valuable, are the savings throughout our entire hospital system made possible by this paper work simplification.

FIG. 2

FIG. 3

Contract Rates for Hospital Service

C. RUFUS ROREM
Executive Secretary
Hospital Council of Philadelphia

THE subject of contract rates for hospital service is part of a much larger problem facing the people of the United States. Costs of hospital care have risen more rapidly than has the national income, especially during the last two years.

Held back by wartime controls, the total expenditures for care in general hospitals, other than federal, was $1,000,000,000 in 1945, $1,200,000,000 in 1946 and probably will reach $1,500,000,000 in 1947. Some of this increase is due to volume of service, some to changes in wages and commodity prices.

Hospital costs are extremely high and will probably not come down very much very soon. Many salaries are still below those paid in private industry. Reduced enrollment in schools of nursing and new opportunities for registered nurses have required hospitals to employ lay assistants who demand wages considerably above the previous maintenance costs of students. This applies particularly to nongovernmental hospitals as contrasted with those financed through taxation. The problem is to reassure the public that present hospital costs are necessary (if they are) and to help organize our buying power to pay these costs (if we want the service).

The basis of reimbursement is always less important to a hospital administrator than is the amount of reimbursement. No basis is equally advantageous to all hospitals. Accordingly, we often find that a general principle is attacked or defended according to its effect upon the finances of a specific institution. But somewhere among the suggestions and experiments in contract payments there must be a basis of reimbursement which assures equity to both hospitals and contract agencies and which is flexible enough to serve during periods of rising or falling prices.

Presented at the American Hospital Association convention, 1947.

Blue Cross the Main Problem

We may assume that the primary interest of nonprofit hospitals is in the contract rates paid by Blue Cross plans. During the present year, hospitals will receive nearly $200,000,000 from this source, whereas the total amount paid during the E.M.I.C. program in four years was only $63,000,000. As to commercial insurance company payments, there is no tendency among either carriers or hospitals to enter into any contracts other than to pay and receive certain amounts of cash which will be applied against a hospital's regular charges.

Nonprofit hospitals and Blue Cross plans are interdependent. The superficial relation is that of seller and buyer—opposing forces. But in the final analysis hospitals and Blue Cross are both agents of the same principal, namely, the general public.

Hospitals are expected to produce adequate care for the members of the public. Blue Cross plans (also governments, community chests, corporate contributors, private patients and donors) are expected to obtain the necessary funds to finance the community's hospitals and to permit them to provide service of adequate quantity and quality.

Hospital Support Is Interrelated

These varied sources of support cannot be considered separately from one another in a complete program of hospital care in America. Nor can hospital service and finance be considered independently of other phases of health and welfare.

The quality and cost of hospital care are greatly influenced by the hospital's economic relations with its medical staff. Hospitals, private physicians and private nurses have been competitors, rather than partners, in their struggle for the patient's dollar and public support. The patient thinks of his sickness bill as a single expenditure caused by a single experience. He will more readily pay a coordinated fee for all services than he will a series of unpredictable charges from separate agencies. All expenses during hospitalization are "hospital bills" in the mind of the patient.

Health service is not everything. Food, shelter, clothes, education and recreation are also highly important. If the cost of health service is considered to be too high, or the method of payment too inconvenient, one may expect a public demand for radical changes in both the production and financing of medical and hospital care.

Short Run v. Long Run

Eight years ago, I expressed myself substantially as follows with respect to Blue Cross contract payments: "In the short run hospitals should expect to receive from hospital service plans *at least as much as they receive from other sources* for similar types and amounts of service in similar accommodations; in the long run they should expect to receive *at least the full proportionate costs of services* to contract patients. These costs should be uniformly calculated and include such elements as are consistent with the general policy of financing hospital care in each community."

In the author's opinion, the most equitable basis for measuring the adequacy of contract payments to a member hospital is the weighted average cost of service for all hospitals in the community, which means simply the total costs of all hospitals during a period of time divided by the total units of service rendered by all hospitals during that period

With the increasing number of contract patients in hospitals, it seems to me that the long run has arrived. Contract patients should now pay the full costs of the total services they receive during a period of time (unless, of course, some other agency or group has agreed to assume the responsibility for any difference).

Uniform Payment Principle Persists

How shall the payments be distributed among the hospitals? We are presented with four alternative bases in this program: uniform payments, regular charges, costs and a point system. Probably no Blue Cross plan makes its payments exclusively on any one of these bases and no method is equally favorable to every hospital in the same area.

In Philadelphia we use all of them. Uniform rates are paid to all hospitals for certain stated contract services. These range from $22 for one day for semiprivate care to $100 for ten days. If a subscriber's bill exceeds certain amounts for special services at "regular charges"—for example, $35 for x-ray—the hospital may charge the difference.

If the regular charges for drugs and oxygen exceed $20, supplementary payments are made based on costs of the drugs, plus a mark up. And, finally, the uniform contract rate just mentioned is payable only to hospitals that meet certain standards, namely, those of the American College of Surgeons. All others receive 10 per cent less—a point system.

The uniform payment principle still exerts a great influence upon all the departures from the original practice. Hospitals are faced with the reality of rising costs on the one hand and the need for increasing revenue on the other. But most hospital representatives feel that payments should not vary too widely in the same community. And most of them appear to feel that certain amounts of payment are "high enough," regardless of a hospital's costs or its need for revenue.

In this practice they exemplify the poem:

Man never knows exactly what is right,
And so betwixt a purpose and a doubt,
He first cuts windows to let in the light,
And then hangs curtains up to keep it out.

Weighted Average Cost

Amid this tempest of discontent is there an anchor of adequacy and reasonableness which will keep the voluntary system of hospital service and finance from drifting toward complete government control? I think so. In my opinion, the most equitable basis for measuring contract payments to a member hospital is the weighted average cost of service for all hospitals in the community.

The weighted average cost for a group of hospitals is merely the total costs of all hospitals during a period of time divided by the total units of service rendered by all hospitals during that time. For example, if the total cost incurred by a group of hospitals during a half year is $1,000,000 and the total units of service (such as patient days) are 120,000 during that time the average cost for all hospitals is $8.50 per day. The average for some hospitals will be higher, for others, lower.

The average gives full "weight" to the larger hospitals which usually render the most units of contract service. The weighted average cost, if paid to all hospitals, would require the contracting agency to pay the same total amount as if different amounts (based on individual costs) were paid to each hospital.

You may ask: Why not pay each hospital the amount of its own average cost? Such a policy, if followed out completely, must be defended on the ground that there is a variation in either the quality of care or the efficiency of management of each institution. But this explanation does not suffice completely to explain the wide variations of cost found in most communities. The weighted average tends to equal "necessary" costs, as incurred by prudent management, for adequate service according to community standards.

Variations From the Average

Limited departures from the weighted average may be permitted for individual hospitals. Slightly higher amounts may be allowed for hospitals recognized as furnishing certain special types or quality of service, and to help meet temporary expenses beyond their control. Likewise, payments somewhat lower may be established for hospitals offering limited service. These may even exceed costs to encourage a higher quality of care.

It will be recognized that the weighted average cost basis is most easily employed when the contract services are comprehensive in character; likewise that the "cost" used as the bases of payment should be the current expenses being incurred by the institutions and not those related to a period long since passed. The application of current costs to this formula requires that member hospitals provide accurate and comparable data in a form satisfactory to the agency contracting to pay the costs of the services. Obviously, some of the hospitals may receive more than their costs, some less. But the general effect would be to encourage efficiency and quality in accord with standards of the community.

Law of Supply and Demand

The weighted average cost for *all* hospitals, as the basis for reimbursement for each hospital, corresponds

roughly to the "marginal cost" which regulates the price of a commodity or service under a system of free competition. But hospitals are not competitors in the accepted use of that term in economics. Each is a benevolent monoply and furnishes a product distinct from that of all other institutions.

The medical staffs, trustees and administrators assert this fact and encourage the public to believe it. The net result is the general conviction — in which I concur — that "free choice" of hospital at time of illness is desirable, particularly at present when bed facilities are being occupied to full capacity. This conviction also is the basis for justifying different amounts for nominally the same service in the same market area.

A program discussing four alternative bases for contract rates would be incomprehensible in an association of private, competitive business enterprises. The matter of contract prices would be promptly settled, in theory and in fact, by operation of the law of "supply and demand." All buyers in the same market would pay all competing firms the same price—or nearly the same. The price would be the amount necessary to bring enough sellers forward to furnish all buyers who were able and willing to pay. If some producers were able to furnish their product at a lesser cost than a competitor's, they would receive the same price and "keep the change." If some had spent more than the public is willing to pay, they would pocket their loss.

If Either Wins, Both Lose

Many factors other than public necessity and convenience have influenced the growth of nonprofit hospitals. These include such forces as the emotion of wealthy donors, the rivalry of certain religious or national groups and the reputation of skillful surgeons. Hospitals are basically the result of the gradual development of medicine into a system of specialization which requires coordination within the institution as well as the community.

Under a master plan, hospitals might have been of different design, different size and in different locations. But plans for the future and action in the present must begin with hospitals as they are. A typical urban hospital represents a replacement value of about $2,000,000. Each must be used in the most effective manner possible, whether or not it is architecturally as efficient as others in the same community.

Hospitals and Blue Cross bear a joint responsibility for service to the people. They are as interdependent as the two blades of a shears or as the thrower and receiver of a forward pass. A voluntary nonprofit hospital system must receive its primary support through voluntary nonprofit agencies and methods. The present struggle between hospitals and Blue Cross must be resolved. A victory for either would be a defeat for both.

A Suggested Program

As a former student and worker in the Blue Cross movement, and as a present laborer for hospital coordination and efficiency, I present the following program for better hospital care for the public:

1. Hospital administration can be, and is being, improved through uniform accounting, joint purchasing and sound personnel policies. There should also be community control of capital expansion and replacement.

2. Outpatient services should be made more readily available to paying patients by the inclusion of outpatient service in Blue Cross and greater use of diagnostic facilities by private ambulatory patients. This would achieve greater utilization of the diagnostic facilities, provide new revenue to meet hospital costs and reduce overcrowding of inpatient facilities by contract and other patients.

3. There should be more flexibility in the use of inpatient facilities. This can be accomplished by reducing the number of beds per room and by architectural design in new construction. At present, many large wards are limited to special types of patients or illness and hence are not utilized to full capacity.

4. Hospitals should encourage prepayment plans for contract patients in minimum accommodations. Many low income workers receive free or part free services which would be beyond the limit of social necessity or convenience provided they had a practical alternative of joining a prepayment plan.

5. Contract benefits should be more comprehensive. This will require active support by the various medical specialists. The noncontract items cause difficulties for patients, hospitals and Blue Cross which far outweigh the Blue Cross economies or hospital revenue presumably derived from their exclusion. Complete service benefits are an incentive for hospital administrators and medical staffs to gauge the services to subscribers by their medical needs.

6. Blue Cross should provide still greater benefits as a reward for high percentage of participation by employes and for employer-contribution. And Blue Cross plans must develop more effective cooperation in their public relations, enrollment policies and contacts with member hospitals.

7. It does not seem to me either necessary or desirable to take regular charges into consideration when establishing long run contract rates. A contract to pay regular charges, without controls, tends to become a form of "deficit financing." It can succeed permanently only when the charges are reasonably uniform and based upon cost, and when the occasions of service are controlled by some standard of professional adequacy. Under any other circumstance, it appears to be necessary to establish "ceilings" for each hospital or the community. It then becomes fairly easy for any hospital to hit the ceiling, which results in a uniform payment at a higher level.

8. In my opinion, the weighted average cost for all hospitals in a community is the most equitable basis for measuring the adequacy of payments to individual institutions. Variations from this average may be justified on the basis of public necessity and convenience, as well as by specific evidence that a hospital renders a particular quality or quantity of service. But ultimately economic force and professional opinion will tend to bring each hospital's cost to a level which the community accepts as reasonable and necessary.

Hospital people are now studying possibilities of controlling costs in the light of rising wage and price levels, also opportunities for greater utilization of present facilities and for obtaining revenue from new sources. As it becomes demonstrated that adequate hospital care costs a certain amount of money, the public (including contracting agencies) must expect to pay these full costs, at whatever level they may be stabilized.

Maternity Hospital Has a Better

Formula for Infant Feeding

ELOISE ROSS

Department of Dietetics, Barnes Hospital, St. Louis

OUR present method of preparing newborn infant formulas using surgically clean technic, applying the nipples and protective covering and final autoclaving has been in use at St. Louis Maternity Hospital for several months. It replaced the water sterilization method and solved the majority of the problems, some of which were: possibility of contamination, length of time, lack of space and number of personnel required.

The results and progress of the autoclaving method, which was initiated when the formula room was under the supervision of the nursing department, are so gratifying that I should like to describe our procedure in hopes that it may be of some help to other hospitals.

I should like to mention at this point that the formula room at St. Louis Maternity Hospital has been under the supervision of the dietary department since Sept. 16, 1946. This transfer was made at the request of the nursing department.

The hospital has four maternity nursing divisions which include four newborn infant nurseries, a premature nursery and an isolation nursery. The formula room is centrally located but is entirely separate from the nurseries. The average census of formulas is 35; the average census of newborn infants is 80.

Dietetic Interns Learn Technic

Formula room personnel consists of one staff dietitian on duty from 8 a.m. to 12:30 p.m. and one attendant on duty from 7 a.m. to 3:30 p.m. Each dietetic intern spends one week in the formula room for the purpose of becoming familiar with the procedure, technic and equipment and acquainting herself with newborn infant nutrition.

The dietitian checks with the nurse in charge of each nursery every morning at 8 o'clock for changes in orders and new formulas. Additional formulas will be prepared if the orders are brought to the formula room before 11:30 a.m. The feeding schedule begins at 12 noon or at 2 p.m., depending upon the number of feedings ordered for twenty-four hours. The dietitian also receives from each floor nurse the names of patients to be discharged from the hospital. A twenty-four hour supply of formulas other than stock formulas is prepared for infants leaving the hospital. Reserve supplies of stock formulas are kept in the refrigerator in the formula room.

While the dietitian is checking orders, the attendant prepares for pouring. The 4 ounce nursing bottles and nipples have been washed thoroughly in green soap solution and rinsed by nursing attendants during the previous night. The formula room attendant covers the two work tables with sterile sheets, carefully inspects the bottles before arranging them in rows on one table and unwraps sterile mixing and pouring equipment on the other table. She removes labels from bottles of sirup and cans of evaporated milk and washes and rinses them thoroughly. The tops of cans of dried milk and special sugars are wiped with a hot sterile towel before the lids are removed.

The efficiency of the formula room is maintained by the method of filing the formulas and marking the bottles. A 2 by 3 foot board with 50 numbered evenly spaced hooks hangs on the wall directly above the table on which the rows of bottles are arranged for pouring the milk mixtures. Sections of the board are designated for each nursery. Each formula is ordered on a hospital requisition form stating the nursery, name of infant, kind of stock formula or amounts of ingredients, number of feedings in twenty-four hours and the amount required for each feeding.

The formula is assigned a number from the designated section of the board according to the nursery. This number, name of infant, kind of stock formula or amounts of ingredients, number of feedings in twenty-four hours and the amount of each feeding are transferred to a 1½ inch square heavy paper tag the color of which designates the nursery. The tag is placed on the hook corresponding to its number.

Also Serves as Label

When the pouring of the milk mixtures has been completed, which I shall describe in detail later, the nippled 4 ounce bottles of formula are covered with caps which consist of a 2 inch square of cellophane secured on the bottle with a cardboard collar. The latter also serves as a means of labeling the bottles.

The number of cardboard collars for each formula corresponds to the number of feedings in twenty-four hours. These are numbered on one corner in blue crayon with the number of the colored tag and are placed in front of the rows of bottles, the number of bottles in each row also corresponding to the number of feedings in twenty-four hours.

For the actual process of mixing and pouring, the staff members wear sterile dresses, turbans and masks

The attendant pours the formulas and can conveniently glance at the formula board to check the amount that is to be poured into each bottle.

and scrub for three minutes with green soap solution and water. The masks are worn while the formulas are being poured and until the bottles are covered and ready for autoclaving. Boiled water is used in the preparation of the milk mixtures. The dietitian combines the ingredients in sterile graduated pitchers. The attendant pours the formulas and can conveniently glance at the formula board to check the amount to be poured into each bottle. The bottles are capped with clean nipples by the attendant under the supervision of the dietitian.

Each nipple is covered with two layers of the cellophane secured by the numbered cardboard collar. The bottles are placed in the autoclave trays and the sterilizing process is begun.

Pressure and Time Factors

When the autoclaving technic for sterilizing newborn infant formulas was being considered, a question arose: What were the lowest amount of pressure and the shortest length of time at which milk mixtures could be autoclaved to rid them of bacteria and yet not change the nutritive value and digestibility of the product?

The opinion is that a pressure of from 7 to 9 pounds maintained for a period of five minutes is as effective as water sterilization in destroying the pathogenic bacteria.* A well known evaporated milk company quoted the pressure and time at which evaporated milk is sterilized stating that there is slight caramelization of lactose in the process and that the protein is rendered more digestible owing to the substantial lowering of the curd tension. It assured us that a pressure of 7 pounds maintained for five minutes would cause little or no change in the nutritive value and digestibility of the formulas, and yet the desired bacterial reaction would be gained.

The standard autoclave measures 20 inches in diameter and 30 inches in depth. It holds a two layer rack which is removable for cleaning purposes. Four autoclave trays fit into the rack. Two of the trays measure 13½ inches by 13½ inches by 6¼ inches; the other two measure 13½ inches by 11 inches by 6¼ inches. Their combined capacity is 132 four ounce nursing bottles.

The rack and trays were designed by the Barnes Hospital maintenance department with the idea of utilizing the capacity of the autoclave to the full extent. They were constructed of stainless metal because of its nonrusting property.

The complete autoclaving process requires approximately twelve minutes. After the trays of bottles are removed from the autoclave, they are allowed to cool at room temperature for a period of from five to ten minutes to remove the initial heat. They are further cooled in a cold water bath. The cooling process was initiated for the purpose of relieving the terrific load of heat from the refrigerator caused by placing the bottles of formula immediately in the refrigerator upon removal from the autoclave. As soon as the formulas have cooled sufficiently, the bottles are placed in the designated sections of the refrigerator according to the nursery. They remain in the formula room until just a few minutes before the feeding schedule when the nurses come for them.

Small-necked pint bottles of 5 per cent sweetened water and reserve stock formulas covered with inverted soufflé cups are also autoclaved by the foregoing process. Extra nursing bottles covered with cellophane secured with a cardboard collar, pint mason jars of nipples and such equipment as hand breast pumps, electric breast pump attachments, bulb syringes and medicine droppers are sterilized by the same method.

Monthly Count of Bacteria

Barnes Hospital's department of bacteriology makes bacterial counts on the stock formulas once a month, the average being 25 colonies per cubic centimeter. Serial dilutions are plated out in pour plates according to the American Public Health Association's standard methods of milk analysis.

As can readily be seen, the advantages of the present method of preparing newborn infant formulas over the one previously used are numerous. There is less possibility of contamination of the nipple because the protective covering is not removed until time for the feeding schedule. The time for preparing and sterilizing formulas has definitely been cut. In addition, the constant supervision by a staff dietitian has removed the heavy responsibility of the formula room procedure from the nursing supervisor and has given her more time for nursing supervision.

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Introducing the Nurse to Society

The Public Relations Problem in Nursing

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THE old code of medical ethics which has been held to apply to hospital activities generally has had its beneficent influences, as every hospital executive knows. The chief activity of the hospital is medical, and no profession that deals so intimately with problems involving human comfort requires more safeguards to protect its practices.

However, the restrictions imposed on the ethical individual or group have been so severe that slight effort has been made by those who are in possession of the scientific facts to acquaint the public with the truth concerning its health. As a result, the sums of money paid out annually for nostrums and patent medicines and to quack doctors who are not compelled to subject themselves to this code are unbelievably large.

From the amount of waste in public and private expenditure brought about by advertising, and self seeking practitioners who know the commercial value of a fear complex, we cannot escape the inference that we have leaned too far backward in our effort to stand up straight. Our approach to the problem of publicity in nursing as well as in other hospital matters will have to be altered if we are to compete successfully for the good will of the public of whose health we are the elected or self appointed guardians.

Nursing Is the Stormy Petrel

In recent years, none of the professions which serve the sick has taken a severer beating than has the profession of nursing. It has been a stormy petrel in hospital life and people have been quick to take sides. The nurse has sometimes been understood but most often misunderstood. Her loyalty to the sick and her strictly nursing pretensions when she transferred from the bedside to other so-called nursing activities which opened up to her and beckoned more attractively have been seriously questioned. She has frequently been denounced for laying claim to professional status when, in reality, hers was a secondary rôle at the bedside.

Some complained that the nurse was overeducated for her special place in life while others dealt with the nursing curriculum as if she was undereducated. Some considered her training apprenticeship too long for subsequent bedside requirements, while others lengthened her course of study as if it was too short. She was glorified as an assistant to the doctor who could even substitute for him in emergencies and condemned as a sickroom drudge. Perhaps worst of all, she was too often glamorized by the public relations man, not at all in keeping with the devotional motive which brought her into the world.

Some concluded that the demoralization of our civilization, which resulted from the two great wars involving the entire world that we know, was having its deadly effect on the morale of the nurse, to the same degree that it was having its effect elsewhere. Others drew the inference, however, that overeducation, overtraining overprofessionalization and the lure of new extrabedside specialties which had been arriving to make use of superior qualifications in the nurse bore a greater responsibility, and they leaned heavily on the fact that the nursing shortage preceded World War II by several years.

The smaller number of available nurses, they argued, bears an inverse ratio to the larger requirements for the practice of nursing. Whichever was correct, and there was doubtless much to be said on both sides, the fact remained that the public relations side of the problem reflected the confusion and was therefore inadequate. It produced, in effect, an intensification of a debate which was too often fought at the bedside of the sick.

Reaping the Whirlwind

Furthermore, it does little good to recall at this time that the nurse was exploited in a most unphilanthropic manner and made to bear the double burden of nursing the sick and helping to pay the cost. To some extent, we have been reaping the whirlwind. The shortage which now prevails is the result of the failure of the supply to keep pace with the demand, no matter how much greater that supply may now be in relation to the output of yesterday.

In the earlier days, publicity was subdued but rather favorable, while nursing blossomed into the fair flower that it remained for several decades. Then the tempo of history quickened while the science of medicine progressed. Few professions escaped the implications of the new world and fewer adjusted properly, among them the profession of nurs-

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ing. As matters now stand, we shall have to move backward a little in order to go forward and the sooner this is done the sooner will the nurse come back into her own.

If the current confused and unbalanced publicity which the nurse is receiving continues, we may find ourselves forsaken and alone during illness. The doctor is almost helpless without the nurse. Let us, therefore, try to introduce the nurse to society, so to speak, in order to obtain a better public response, both in appreciation of her services and in the recruitment of an adequate student body.

Must Pool Their Efforts

The public relations expert, with selective interest in the nursing problem and with a highly trained approach, can bring his talents to bear on it so that people will not stand aloof or echo destructive opinions uncritically. No one who is aware of the distressing course that events in the nursing world have taken these days can escape the thought that the time has come when publicist, hospital expert, physician and nurse must pool their efforts in a determined attempt to right the situation. There is no alternative.

Nursing has had a bad press of late. We must find and remedy the cause, while asking for a sympathetic hearing by the public. It is idle to complain that the nursing leadership became more and more impractical as it raised standards and overreached itself in recent years.

Just as we are now on the verge of solving the major problems of nursing education, which we ourselves have created, so are we on the verge of solving the major problems of nursing economics. Whatever the causes of the nursing shortage, they have been tackled with some success of late. Witness the advent of the practical nurse who revives the original pattern of nursing which we have found, after all, to be timeless and unchanging. She is slow in returning and is being accepted grudgingly by some of the academicians in the profession, but she is here, and I venture to predict that the presence of the practical nurse will guarantee the permanence and integrity of the nursing profession as a whole. Graduate registered nursing will survive only in the presence of the practical nurse; without her it will disintegrate and have to be done all over again.

The exploitations of yesterday, within the school of nursing and also outside of it, are crumbling under the pressure of the law of supply and demand if for no other reason. We are learning that bedside nursing must be adequately compensated. Devotion to the patient is purchasable within reasonable limits. Nurses cannot survive on good deeds alone.

The causes for the migration of the nursing profession away from the bedside must be publicized in such a friendly way that the community will understand nursing values — and opportunities — more clearly. This will in turn benefit the recruitment programs of our various types of nursing schools. One can I presume, if so disposed, look upon this migration as a gigantic strike against the prevailing conditions under which a nurse must serve the sick, but this would be oversimplifying the explanation while neglecting to take more basic factors into consideration. We must hope that the public relations expert will make no such mistake.

The history of nursing, which goes much farther back than Florence Nightingale who gave the modern public relations program for nursing its greatest argument, must be retold in simple language so that he who runs, and he whose heart is a few pulses ahead of his brain. can read and understand. It is a noble story and one that can be told in simple human terms. The publicist must tell it as an illustrative example of the power of mutual aid during illness.

Here is a writing job that does not call for overstatement, excessive color or modern glamour to be effective. The story is as simply told as the tears of a child, the groan of the afflicted or the sigh of the bereaved. *If I were asked how the word "nurse" originated I would say that it had something to do with a mother nursing her child to give it sustenance and protection in its struggle for life.*

It should be made clear to the public that the industrial revolution is here to stay, because it is irreversible. Specialization and the division of labor in health and medical work, resulting from the great inventions and discoveries in the field of social and medical diagnosis and therapy in our time, affect doctor and nurse to the extent that new careers are constantly appearing on the horizon for those who serve the sick and the near sick. The practice of nursing, like the practice of medicine, must respond to compelling situations like these.

The need for adjustment which the nurse feels when she sees these new horizons before her should be publicized at this time rather than the mistakes which are being made in the course of these adjustments. People naturally respond to material attractiveness, as well as to spiritual attractiveness, and the balance of nursing power is likely to shift disastrously in the process if it is not intelligently guided and controlled.

It is idle for anyone to blame the entire nursing profession for the defections of the last decade, when adjustments often had to be made by the nurse under adverse prevailing conditions. It is not the fault of the nurse when she moves forward to better opportunities which she deserves; it is our fault if we do not find a more stable means of replacing her at the bedside. No woman should be asked to remain in the lesser post when a greater one beckons for which she is fitted. And many new pastures have been opening up in the last decade to the nurse's delighted gaze! What is more, and I do not say this in criticism, these new pastures in the nursing specialties have had a better press than the older one at the bedside.

Practical Nurse Is Returning

With the tempo of change in the modern world, the professional picture changes kaleidoscopically. We have seen the danger of bizarre social patterns, which may assemble like a crazy quilt when relative values have been forgotten. It is clear that the practical nurse has returned to set matters right again and to restore the balance in the nursing world. The public relations officer should, however, know that she is not arriving fast enough or in sufficient numbers. He must help to popularize the qualifications and opportunities of the bedside worker. This, let it be said, is the latest chapter in the history of nursing.

Practical bedside nursing must be publicized at the same time that the desperate need of the sick is publi-

cized. If these are not treated as inseparable subjects, none but the sick will suffer by it. If the practical nurse is not here to stay then no one, and least of all the nurse educator, has thus far brought forth a better method of dealing with the nursing shortage.

Our task is to find and train women for specific nursing jobs. Each specialized job, including the basic one of bedside nursing, calls for its own special prerequisites and training qualifications. You do not need to know Latin in order to administer medication. We must start building from the foundation and not from the roof, and if we do we shall find an excellent interpreter in the modern public relations expert.

It is no small part of the public relations expert's job to overcome the possible fear of nursing as a profession, from whatever cause. No profession in which a woman can engage offers more direct and indirect rewards in this world and, for those who wish them, in the next. The progress of education may continue and adjust itself in new fields of nursing but the bedside aspects of nursing are basic and therefore primary on the agenda.

An Expert Is Required

The hospital must be conscious at all times of its public relations responsibilities and nursing is a good illustration of this requirement. You cannot rely on haphazard, nonprofessional, sporadic and incompletely informed publicity for such a vital activity as nursing. In large hospitals this is a full time job and in medium sized hospitals it is a part time job. In lesser hospitals it must be done on a cooperative communal basis or by establishing an account with an interested firm of public relations experts. In any case, every step forward in the hospital, and every one of its needs, should be entrusted to the public relations expert for translation to the public in the simplest and most effective terms, through the most influential mediums of publicity with which he is conversant.

The public relations product has two aspects, which must blend in a manner that will make them indistinguishable. The first is public education, which makes the public relations expert kin to the teacher. The second is advertisement, which makes a partisan out of him, since it has for its primary objective the fixation of the subject in the mind of a suggestible clientele. Newspapers are no courts of law, though one might think so at times when reporting is one sided, tendential and incomplete.

If these propositions are acceptable, then the subject of nursing is timely, newsworthy, interesting if not vital, and remedial, when handled by the professional public relations expert as the pressing problem that it is. There must be a meeting of minds, in which hospital executive, physician, nurse educator and public relations expert come together to formulate a plan on behalf of the patient, who must necessarily stand helplessly by since he cannot join the healthy participants on whom he must rely to defend his interests. Careful editing must be done in order to make certain that the information is clear, accurate, dignified and dispassionate.

Where the public relations expert serves on a full time basis he should have the status of an administrative department head directly responsible to the director of the hospital and, indirectly, to its board of trustees through a special standing committee on public relations. He must be steeped in the history, traditions, atmosphere and program of the hospital and be available at all times and on short notice to interpret his hospital to the public in such a way that it will command confidence and support for all of its activities, including nursing activities. He is the chronicler of events whose efficiency will be judged by the ability of the hospital to adjust to changing conditions as well as to pioneer in new fields.

This is a large order for any hospital worker to fill, but it is a worthy one, because a sick clientele depends upon it. It goes without saying that the public relations executive should receive a fair wage because his very presence and availability are investments of a high order. Besides, this is in the nature of a public debt which the hospital must discharge, regardless of financial returns.

The public relations expert, particularly in the field of nursing, has a reciprocal function to perform. He must help to interpret the public to the hospital. With his ear to the ground in the area served by the hospital, he must be sensitive to public reaction and be able and ready to interpret and report it intelligently. The press, the radio, the screen, the stage and the platform are the mediums which he must harmonize and which he must use intelligently, as well as in the friendly manner that hospital service in any community requires.

With the adoption of these basic public relations concepts we need have no fear for the future of nursing, however great and widespread the prevailing discomfort on the subject may be.

Instrument Ready at Hand

That a good public relations program can help to reestablish the place of nursing in the hearts of the public is, I believe, beyond question. It is an instrument which is ready at hand for intelligent and productive use. Without it, we must continue to flounder in a confused and uncertain world which is now struggling to recover much of its lost civilization and take the consequences from which we have already been suffering too long. With it, we shall go forward, stimulating medical and nursing progress to greater and greater heights and bringing life and comfort to those who call to us for help.

Administrative Capsules

- Hospital administration is not an end in itself. It is only a means to an end.
- Philanthropy deserves a return on its investment and it is learning from the profession of social service, as well as from the scientist, how to get it.
- The balm may come from Gilead, but it takes a divine spark in the physician to apply it effectively.

PEOPLE IN PICTURES

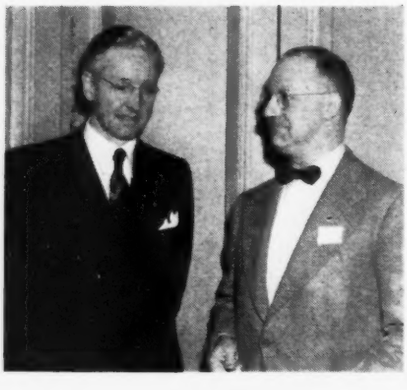
Above: Class and faculty of Colby College Institute at Waterville, Me. In the front row, l. to r.: Dr. Frederick Hill; William Donnelly, Greenwich, Conn.; R. P. Sloan; two students; Abbie E. Dunks, Boston; two more students; Mary E. Curtis, Colby College, and Dr. Joseph C. Doane, Philadelphia. In the second row are Dr. Seelye Bixler, president of Colby College, extreme left, and directly behind the two nuns, Pearl Fisher, Thayer Hospital, Waterville.

Above: Newly elected board of the New York State Nurses' Association, first row, left to right: Iona B. Riedel, second vice president; Mrs. Mabel Detmold, president; Clare M. Casey, outgoing president; Mrs. Dorothy D. McLaughlin, director. Standing: Alice Pearsall, secretary; Mrs. Gladys Spirson, treasurer; Albert E. Launt and Gerd Oyen, association directors.

U. S. Public Health Service photographer.

Above: Approval of the first application for federal funds for building a hospital (Chattahoochee Valley Hospital, Langdale, Ala.) under the Hospital Survey and Construction Act is signed by U.S.P.H.S. Surgeon General Thomas Parran and Federal Security Administrator Oscar R. Ewing.

Above: Doctors in attendance at the American College of Surgeons meeting witness an operation by television. Below: Student nurses at Muskogee General Hospital, Muskogee, Okla., gather for tea at Rockefeller Hall. Supt. Edna M. Rockefeller is standing second from right.



Left: Nelson Cruikshank, new member of the Federal Hospital Council, succeeding Clinton S. Golden, chats with Robert Whitton, administrator, Alexandria Hospital, Alexandria, Va.

The General Hospital's Contribution to The Eradication of Tuberculosis

CHARLES T. DOLEZAL, M.D.
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EFFICIENT management of tuberculosis in the general hospital requires the utilization of segregated patient accommodations and the development of an effective program of infectious disease control. Inasmuch as many of the procedures necessary for the protection of patients and personnel are not included in standard general hospital practice, confusion and inefficiency will be avoided only when the basic principles of infectious disease control are clearly defined and properly presented to all groups of hospital personnel.

Must Realize Shortcomings

In order to assume its proper rôle in the improvement of the public health, it is imperative that the general hospital recognize its past shortcomings in the management of unrecognized cases of tuberculosis and institute adequate measures for their recognition and efficient treatment. After many years of study and experience, hospital and tuberculosis authorities are now in accord that successful organization within the general hospital for the reception and care of the tuberculous patient should embody six essentials:

1. The development of a control program under the supervision of a physician with experience in the management of tuberculosis as medical director.
2. Examination of all admissions for tuberculosis.
3. Periodic examinations of all hospital personnel.
4. Establishment of adequate facilities for the admission and placement of tuberculous patients.
5. The use of infectious disease precautions.
6. Provision for the proper education of patients and hospital personnel.

The most valuable method of detecting the presence of tuberculosis which might be otherwise unrecognized is the routine x-ray examination of the lungs. This method of case finding should apply to all inpatients, outpatients and hospital employes. When the volume of x-ray work is large, the method of choice is the use of miniature films. Either the 35 or 70 millimeter camera film or a 4 by 5 inch photoroentgenographic film can be used.

Hospitals that have instituted this procedure have found it convenient to install this equipment either in the regular x-ray department, in the admitting room, if the hospital is large, or in the outpatient department. Depending upon the volume of films taken, the unit cost of taking a miniature film, including technical service, will average between 60 cents and $1.50. Properly regarded as a public health measure, the cost of this procedure should be incorporated in the hospital rate and should not be assessed to the patient as a special charge.

In order to conserve time, the interpretation of these films is usually made by the radiologist in code, signifying either (1) tuberculosis suspected; (2) tuberculosis negative, or (3) abnormalities other than tuberculosis. In cases of questionable diagnosis, 14 by 17 inch films are advisable when requested by the radiologist.

The incidence of tuberculosis among hospital patients has been found to vary from 1½ to 4 per cent. Other abnormalities of the chest, such as lesions of the heart and aorta and nontuberculous diseases of the lungs and pleura, have been noted in as many as 20 per cent of the people examined.

An equally important part of the hospital case finding program is the examination of all personnel. For this purpose a practical program consists of, first, a preemployment physical examination, including chest x-ray of all new employes. This is a most valuable procedure, for the protection of both the hospital and the employe, because under workmen's compensation laws a negative preemployment chest x-ray may be required as the basis of a claim for occupationally acquired disease. Second, there should be periodic x-ray examinations of all regular hospital employes once a year.

Doctors, nurses and lay employes in direct contact with tuberculous patients should have x-ray examinations every six months, and in the case of younger groups, every three months. Fluoroscopy can often be substituted effectively for x-ray.

A final procedure, and the one oftenest neglected, is the x-ray of the chest six months and one year after termination of employment in a tuberculosis unit. Because tuberculous lesions usually develop insidiously and without clinical symptoms, periodic x-ray examinations after completion of their service or transfer to other units of the hospital should be routine performance in the case of resident doctors and student nurses.

In addition to x-ray examinations, tuberculin tests should be performed on all new employes of the tuberculosis unit and yearly thereafter on all negative reactors.

B.C.G. Immunization

Another means of providing protection against tuberculosis to hospital employes who are tuberculin negative is immunization with B.C.G. (Bacillus of Calmette-Guerin) vaccine. Reports of its use by the Indian Service of the U. S. Department of the Interior, the Tice Clinic of the Chicago Municipal Sanatorium and the Provincial Sanatorium in Saskatchewan show that approximately five times as many cases of tuberculosis occurred among the unvaccinated as among the vaccinated. Immunization with B.C.G. vaccine preferably should precede exposure to tuberculosis by six weeks. Successful immunization is believed to afford protection for from three to five years and possibly longer.

Presented at the American Hospital Association convention, 1947.

Our experience with this vaccine at City Hospital, Cleveland, is limited to the group of student nurses, of whom approximately 80 have been vaccinated over the last three years. This series is too small and the time much too short to permit any conclusions, but we can report that the experience of the vaccination itself, done by the Rosenthal multiple puncture technic, was quite uneventful.

There were no sore arms and no constitutional reactions. There was 100 per cent conversion to positive tuberculin reaction after six weeks. A blanket permit form in which tuberculosis was listed with the other routine tests and immunizations that are required of student nurses was used. No objections or refusals to sign this permit on the part of students were encountered.

Allocating TB Beds

Separate facilities for the placement of tuberculous patients may consist of a small division, a department or a separate unit operated in conjunction with a general hospital. Admission may be for temporary hospitalization, medical care only or for complete treatment, including chest surgery and rehabilitation. Bed capacity is best regulated in accordance with community needs, the proximity of special tuberculosis hospitals and existing arrangements with county or state governments which are legally responsible for providing such care.

In planning for the establishment of efficient facilities for the care of the tuberculous, consideration must be given to the fact that tuberculosis is now recognized as a specialty; that many specialized procedures are utilized in its treatment, and that efficiency and economy can be attained by the performance of these specialized procedures on a mass basis. Successful administration of the tuberculosis unit or department is best achieved under the supervision of a physician with experience in the management of tuberculosis, functioning in the capacity of medical director. His principal duties are the supervision and direction of the patient's care; the instruction and training of the resident house staff; consultations with regular staff physicians, and the integration of his department with regional tuberculosis hospitals, health departments and social agencies for the ultimate rehabilitation of his patients.

Efficient operation requires that all treatments be carried out by the house staff under the supervision of the medical director. The private physician necessarily plays a smaller part in the tuberculosis unit than he does in the general hospital, although he can and should consult with the medical director regarding choice of procedure to be used and the clinical progress of his patient. This is not a matter of great importance because the great majority of tuberculous patients are the responsibility of some governmental unit.

Perhaps the most difficult problem in the organization of a tuberculosis unit is the procurement of an adequate staff of graduate nurses trained in aseptic technic. As the dearth of nurses with experience in tuberculosis is largely the result of the failure of many schools of nursing to include tuberculosis in their curriculum, it is important that training be given to students in the home school or by affiliation in a tuberculosis unit.

To accomplish this purpose it is recommended that the nursing staff of a tuberculosis unit consist of a permanent and separate nursing staff headed by a capable nursing supervisor and instructor in order to ensure proper integration of instruction with practical experience.

Minimum standards of bedside nursing hours adopted by the three national nursing associations, and the only standards of this sort in existence, are bed-surgical patients, 3.3 hours per patient day; bed-medical, 2.7 hours; semiambulant, 1.5, and ambulant, 0.5 hour. The total nursing hours provided should be in excess of these standards, as their computation includes all of the time of the staff nurses, plus half that of the assistant nursing personnel, such as ward aides, attendants and orderlies, but excludes all the time of the head nurses.

Both maximum efficiency and economy of the nurses' time are best effected by classification of patients into the four previously mentioned groups. Patient accommodations should be arranged for the convenience of handling patients in accordance with this classification. Single rooms are considered most practical for bed-surgical and bed-medical cases and for newly admitted patients, from 5 to 10 per cent of whom are statistically found to be nontuberculous.

Double rooms are considered satisfactory for minimal and semiambulatory patients, while three or four bed rooms are usually adequate for ambulant and convalescing patients. On this basis patient accommodations in a large unit should be: single rooms, 50 to 60 per cent; double rooms, 20 to 40 per cent, and three or four bed rooms, 10 to 20 per cent.

The basis of control in the management of tuberculosis is the routine employment of infectious disease precautions, commonly known under the terminology of isolation or aseptic technic. Brief reference is made to the theory of aseptic technic because medical asepsis which aims to confine contamination to a definite area (that is, the infected patient and his immediate surroundings) is regularly practiced in medical, dermatological and pediatric divisions of the general hospital. Surgical asepsis, which aims to prevent contamination from entering a definite area, namely the field of operation, is the technic employed in surgical divisions, operating rooms and obstetrical departments.

Successful execution of aseptic technic in the management of tuberculosis involves the use of the basic principles of both medical and surgical asepsis. The mechanical means utilized for providing protection to both patients and employes are the cap, mask, gown and hand washing.

Serve a Dual Purpose

Successful application of aseptic technic requires that doctors, nurses and all other employes remember that mechanical agents serve a dual purpose: they protect the worker from organisms given off by the patient and they protect the surrounding area from contamination by the worker; that caps, masks and gowns should therefore be handled with this dual purpose in mind and discarded accordingly; that frequent and adequate hand washing must be practiced conscientiously, and that mechanical agents properly used furnish a satisfactory means of protection where other methods cannot be utilized. However, when improperly used they may become a menace.

The first step in the development of a program of aseptic technic is

the definition of areas and objects in relation to their relative degree of contamination: (1) uncontaminated and always to be kept that way; (2) contaminated and always to be so considered, and (3) contaminated at given times during routine procedures but uncontaminated after procedures are finished and routine cleaning is completed.

The second and equally important step is the routine practice of procedures in the care of the patient and his environment, with proper protection for personnel and visitors. Specific instructions for the practical application of these procedures can be found in the manual of the American Hospital Association, entitled "The Management of Tuberculosis in General Hospitals."

The third step is the coordination of the tuberculosis unit with other departments of the general hospital for the purpose of making all of its diagnostic and therapeutic resources available to the tuberculous patient. Simple precautionary measures may be undertaken in the following manner: Transportation of the patient to any other department of the hospital may be by means of any wheelchair or cart. The vehicle should be covered with a sheet during the ride or wiped off with saponated solution of cresol after contact. When sent to surgery, the clinical laboratory or x-ray department, the patient wears a clean hospital gown and a mask. The technician then proceeds as with any nontuberculous patient.

Safe handling of laundry is accomplished by placing all items in a bag which is identifiable by special marking or color. The bag goes directly to the hospital laundry where the contents are not handled further until after they are washed.

Food from a central source of supply is handled in accordance with the principles of aseptic technic. The food cart as well as the kitchen are considered initially uncontaminated. A clean nurse or maid transfers the food from the food cart to the kitchen and serves the tray to the patient. The returned tray is considered contaminated and is scraped off; the dishes and tray are washed and sterilized with steam. All food returned from the patient's tray is destroyed as contaminated.

As the tuberculous patient often remains in the hospital for a period of from four to eight months, or even longer, and as his activity is restricted in some degree for considerable time, special services designed to lessen his fear of the disease, to enlist his cooperation and to improve his morale should be provided.

Instruction at the time of admission by the admitting nurse, or by a well trained patient education instructor, as to how to avoid excessive coughing, how to cover the mouth, prevent contamination of the hands and how to dispose of sputum is most helpful to the patient. Routine follow-up instruction, educational bulletins and public address system talks help immensely in building patient morale. Periodic visits by the therapeutic dietitian, review of patients' menus, provision for extra nourishment, birthday parties and holiday patient tray arrangements are other valuable adjuncts for this purpose.

Experience has shown that semiambulant and ambulant patients require occupational and recreational therapy in order to maintain a healthy psychological adjustment to institutional life. In the case of younger patients, vocational rehabilitation is also necessary to ensure the permanence of their recovery and their successful readjustment in the life of the community.

If the tuberculosis unit is not sufficiently large to provide rehabilitation facilities, an alert social service department can often overcome this lack by full utilization of resources available in the community for this purpose.

In summary, I should like to leave with you the thought that the administrative problems relating to the organization of a tuberculosis unit within the general hospital are not insurmountable. Neither are the risks to personnel beyond reasonable control. The basic elements of infectious disease control are already in practice in many of the departments of the hospital.

Finally, progressive improvement in the treatment of tuberculosis in recent years has removed it from the category of a chronic disease which formerly required only isolation and fresh air. Because of its varied resources, the general hospital can now make a valuable contribution toward the final eradication of tuberculosis by the institution of proper case finding methods and adequate facilities for its treatment.

We Must Use All Our Tools *to make our* Public Relations Program Public

LONDON P. CORBETT
Director of Personnel and Public Relations
California Hospital, Los Angeles

Mayor Fletcher Bowron presents Miss Williamson with a letter to Mayor O'Dwyer of New York City.

TODAY in the hospital field we have a need greater than ever before for reaching the outside world, reaching the man in the street with our message. We can't pretend any longer that we are appealing solely to the carriage trade, the social register. We must definitely reach the tabloid man.

Many of our institutions have been reticent because they felt the inadequacy of their equipment. It may be true that many of our institutions need more efficient administration, many of our institutions need more inspired administration. But really we have been modest too long; it is necessary that we operate with efficiency and inspiration, but it is also necessary that we go to the outside public with the story of what we are already doing and what we need it to do.

A recent event at our hospital provided an experience that is typical of this phase of public relations. First, however, permit me to emphasize that "publicity" plays only a small part in the well planned public relations program. In addition to the usual assignments in a typical hospital routine, the director of personnel and public relations in two hospitals finds life full and varied. Press releases are, in essence, merely by-products, as we shall now illustrate.

To shorten and perhaps to organize this story, we shall tabulate it as a sort of case history:

Purpose: To emphasize the nursing shortage to all people and to publicize the improved conditions of nurse training and nursing as a career.

Statement of Facts: Our nurse, Anne A. Williamson, R.N., aged 79, graduate of Cornell University-New York Hospital School of Nursing, class of 1896.

Fifty-one years a nurse—eighteen years director of nursing at California Hospital, twenty-two years as director of social service.

In 1898 one of small group of nurses who were first women to be permitted to serve in U. S. Army.

In 1910 director of the field hospital at first air meet ever held in the United States at Dominguez Field, Los Angeles.

Author of nearly completed autobiography, "Just Another Nurse."

Invited by Cornell University-New York Hospital School of Nursing to attend seventieth anniversary dinner, April 16.

Action: Decision to send Miss Williamson, R.N., by plane to New York.

Conference at City Hall: Mayor Bowron of Los Angeles agrees to send letter to Mayor O'Dwyer of New York emphasing acute nurse shortage.

Conference with TWA public relations director: his agreement to cooperate with news releases because of age of nurse, her past experience and the letter from the mayor.

Letters, releases and telephone calls to city editors, national press bureaus, radio.

Notification of these plans and activities to: *Virginia M. Dunbar,* dean, Cornell University-New York Hospital School of Nursing; *Mary M. Roberts,* editor, *American Journal of Nursing; Lucile Petry,* chief, Division of Nursing, U. S. Public Health Service, Washington, D. C.; *C. J. Foley,* Council on Public Relations, American Hospital Association; *E. E. Salisbury,* executive director, Chicago Hospital Council; *John Hayes,* president, American Hospital Association, and *Helene J. Jordan,* director of public information, Cornell University-New York Hospital School of Nursing.

Results: Cooperation from all who were advised in advance, resulting in a total of 14 newspaper stories with pictures, one national press release, two national radio reports.

The appeal in all these stories was of course the "personality in the news," but in almost all instances they carried meaningful quotations either from the mayor's letter or from Miss Williamson's interview as follows: "I'm not flying around the country for the fun of it," she

quipped, "I'm told this is one way to demonstrate to the high school and junior college girls that a nurse is a human being, and that her highly skilled career is not humdrum but is sometimes exciting and provides a life of personal satisfaction."

The best story and greatest attraction was unplanned but most effective.

Miss Williamson left Los Angeles at 9:15 Saturday morning April 12. Less than an hour in flight, a baby became ill. Now there were two hostesses on this 52 passenger plane but, "owing to the nursing shortage," neither of these girls was a nurse so Miss Williamson was summoned to give her professional services to a very young passenger. In her opinion, it was a case of too much altitude. She ordered increased oxygen, but the baby failed to respond. Miss Williamson then sent a message to the chief pilot, asking if he could land. He replied that the field at Pueblo was large enough but he would not land unless she ordered it as "essential." Miss Williamson who had stood beside a thousand patients never hesitated as she fired right back: "I declare it essential to the life of this child that you land as soon as possible and that you radio ahead for a doctor and an ambulance."

Airline Officials Grateful

When the big Constellation landed at the Pueblo field, the doctor was at the door and took charge of the baby immediately. Unfortunately, this emergency stop caused a two hour delay, and the Los Angeles-New York schedule eventually took a bad beating. However, the doctor reported that the baby could not have lived another hour aloft and plane officials seemed genuinely grateful to the trained nurse who accepted responsibility and acted with courage.

It is our sober conviction that one story like this widely circulated in press and radio says more to more people than all the trade journals and brochures would in a year. However, we must never lose sight of our perspective. Press stories can be interesting and gain the attention of our larger public, but once we have gained that attention we can most efficiently follow up the newly created interest with our own well prepared materials. We must use all the tools at our command.

Adjusting *Hospital* Service to *Medical* Progress

IRENE E. OLIVER

Administrator, Tompkins County Memorial Hospital, Ithaca, N. Y.

WE ARE living in a period of breathtakingly rapid scientific advancement and this advancement parallels and influences the social changes that are occurring simultaneously. Medical progress is a single facet of the general progress and change now going on, and while medical goals are clearly defined social goals are not so clearly defined. Hospital administration, however, is obliged to take both into consideration.

(For the purposes of this discussion, it is necessary to point out that the term "social" is used in its broadest meaning, as it refers to human progress, and not in its narrower or purely political-economic definition.)

Thus it is incumbent upon us in the field of hospital administration to attempt to keep pace with medical advancement at a particularly difficult time, for we must act and make far reaching decisions in an era of social transition. Too much emphasis cannot be given to this matter of the rapidly changing social scene. Satisfactory hospital administrative progress must harmonize with it inasmuch as such change is the keynote of our time.

Generally speaking, the medical progress and the social progress that have taken place in little more than a decade have presented hospitals with a triple problem:

1. Hospitals have ceased to be institutions destined solely for the nursing of the critically ill, those requiring surgery or intensive medical therapy. They have become modern medical and health centers with the greatly widened concept of health services that the name implies, including preventive medicine, care of the convalescent, chronically ill and neuropsychiatric patient. Hospitals of the future must begin at the beginning and carry through until the end of the disease by adding home medical care as one of their activities.

2. To meet this dynamically changed concept of the function of the hospital, hospital administration must use existing physical plants that are extensive and costly and yet are wholly or in part inadequate to meet the new demand. On the human side, we must reckon with boards of trustees, staffs and personnel whose training and experience were accomplished under the earlier and now obsolete concepts of hospital and medical care.

3. We now have widespread hospitalization insurance which of itself would more than double the demands of the public for hospital care.

Hospitals that serve the small urban community and surrounding area bear the brunt of the constant attacks which disease and accident bring upon the population. Upon their number, capacity and, above all, their quality, the safety of our people must depend. Acute illness and accident victims rarely choose among two, three or five hospitals; they are taken to the nearest. If that hospital is a good one, the victim has a much better chance of quick recovery. Therefore, it is to the small urban hospital that I wish to address my remarks.

Among the factors that require

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adjustment in the small urban hospital are: the administrator himself; the physical plant; the personnel of the institution, including the board of trustees, the medical and nursing staffs and employes, and the public. Brief consideration will be given to each of these in turn.

Adjustment of the Administrator. We administrators can reorient ourselves by realizing that we must be constantly on the alert for current trends in medical and hospital care in all its ramifications. In order to have time for this, we must apply the principle of delegation of duty and authority so as to have opportunity for study and to pass on a digest of our study to our associates. The administrator must be the interpreter to the board and medical staff, to hospital personnel in general and, above all these, to the public.

Adjustment of Physical Plant. Perhaps the least difficult adjustment is that of the physical plant, because most people find it easier to confront the tangible than the intangible. A physical plant must be so designed that it will meet the needs for expansion in the years ahead. In this broad and new picture of what hospitalization means to the community, the scope is so great that approach must be made through the integration of all agencies rendering health services to a given population area.

Many of us are dealing with outmoded plants. New construction is the ideal solution, but with cost such a formidable problem at present, many of us must use ingenuity in improvising and rearranging existing facilities. It is necessary to evaluate the scientific discoveries that create requests for new equipment. The smaller hospital has an especially thorny problem because it cannot afford to embark on ill-founded or unproved scientific advances.

Adjustment of Personnel. The adjustment of personnel is primarily a matter of education. Boards of trustees need to be kept up to date in these changing times. The medical and nursing staffs which are wholly occupied in carrying the burden and are concerned with the application of established principles have difficulty keeping abreast of many of the trends. If the administrator can focus their attention upon major issues, even fleetingly, it will be of benefit. Great tact is indispensable for the accomplishment of this goal, for insecurity in the face of new ideas is an inevitable reaction.

It may be necessary upon occasion for the administrator to assume the lead even when it is fully realized that in a particular situation some infringement of the prerogatives of one of these groups may be temporarily involved. Naturally, this is a last-ditch method, only to be resorted to when tact and education have fallen short of their accomplishment.

The nonprofessional personnel shares to some extent the current attitudes of organized labor. This fact needs to be recognized and dealt with realistically, rather than deplored and ignored. The approach to employes, therefore, needs to be made in terms of salary for services rendered rather than in terms of education or the appeal to their devotion to hospital service and community welfare. Fair dealing in apportionment of hours and improvement of working conditions, in conjunction with insistence upon the doctrine that a fair return of production is expected for salary received, would seem a sound administrative policy.

Adjustment of Public. The value of enlightened public support is basic; it must be continuously cultivated. Obviously, the facilities of the hospital cannot achieve maximum usefulness to the community if the public is ignorant as to what facilities exist and how they compare with the best modern development of medical and nursing care. Public criticism can be expected to be reduced only in proportion to the public's increased understanding of what a hospital is supposed to do and what is required in order that the job may be done to everyone's satisfaction. Close and cordial liaison with the press and radio is, of course, of utmost importance.

If they can be shown the need, groups "in the know" about the hospital and its functions prove useful in forwarding the program. Their approach is more personal and probably more effective even though they reach a smaller segment of the population. The medical and nursing staffs are best qualified for this mission. Volunteers and hospital auxiliaries should certainly be asked to participate.

However, in the last analysis, it is the esprit de corps of the hospital and medical staff as it is manifest to the patients that is the cornerstone upon which all else must be built in the hospital's relation with the public. It cannot be denied that a hospital is as good or as bad as its medical staff permits it to be.

Do Voluntary Hospitals Have a Future? It is becoming increasingly clear that a new aspect of adjusting hospital services to meet medical progress must be taken into consideration: how the community's health bill is to be met.

To answer this question the hospital must exert its leadership in pooling all of the community's actual and potential financial resources, public and voluntary, in order that a broad preventive, curative and remedial health program can be realized. In exact proportion as the community fails to do this under voluntary hospital leadership, government will be forced to experiment. In the case of the general hospital serving the smaller urban community and environs, increasing indications are that when government is forced to take the leadership it may also take over operation of the hospital itself.

The New York State Health Department's county health unit program for counties under 50,000 population is planned to operate from a tax-supported county general hospital, with 50 per cent of the annual operating deficit met by the state. In predominantly rural counties lacking urban communities with genuine resources for voluntary hospital support, this is probably a reasonable development. The question and challenge I wish to raise here, however, are directed to those urban communities that do have special resources for voluntary hospital leadership and support.

In my own community which has some of these resources, namely, a large university, several sizable industrial concerns and an economic level far above the average small urban community, these resources have been undervalued for years. As a result, the hospital now finds itself with such a burden of indebtedness that in all probability we are going to have to look to tax support in order to maintain and improve our services for the future.

Our tragedy, if this happens, is that we may forfeit the freedom and incentives that a voluntary hospital would enjoy in the development of a health center, because of the sins of omission committed in the past.

The moral of our experience for all hospitals and the communities they serve, particularly for those in smaller urban areas, is that voluntary interest *now* will determine the degree of tax support that will be needed in the immediate future. And that voluntary interest can be effective only through the pooling of all community medical, health and hospital resources, both public and voluntary.

In smaller communities an effective pooling of doctors, health departments, universities, corporation or industrial interests with the resources of the hospital can have an immediate impact, which, because of the size, will be much more apparent than is the case in larger metropolitan communities.

This cannot be done without genuine pioneering in the areas of health insurance; it includes welfare and medically indigent patients. It also presupposes the willingness of the medical profession to scrap those aspects of professional ethics and political self interest that place profession before patient. Above all, fees to patients must be related to the reasonable ability of patients to pay and should not be so heavy as to deter people from seeking the care they need.

One thing is certain, if the problem of supporting voluntary hospitals is not met by inter-association of lay and professional groups of the community, we shall have to submit to the attempt to accomplish the same ends under the controls of government.

New Horizons in Hospital Care

J. J. GOLUB, M.D.
Director, Hospital for Joint Diseases
New York, N. Y.

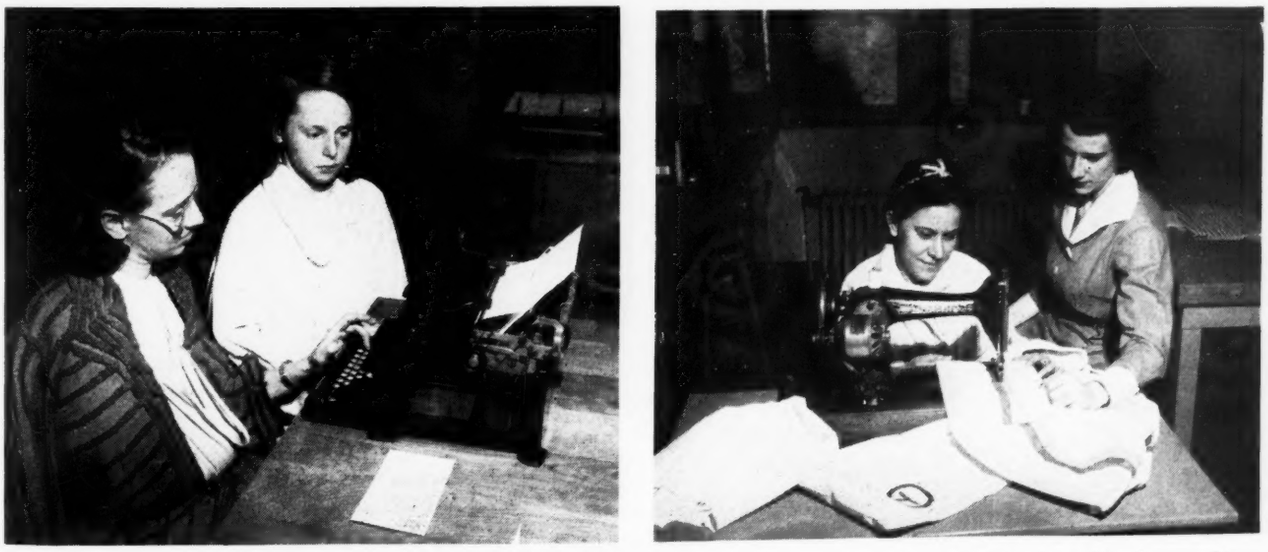
IN SPITE of the changing order in the medical world and in hospitals, traditional hospital aims are still largely governed by precedent. The hospital continues to be a place where disease is diagnosed and treated and patients receive medical care; where physicians learn and teach medicine and medical students and student nurses are taught; where clinical and laboratory research work is pursued, and where, in some cases, patients and their families receive the benefits of medical social service.

These aims are commendable and must at all times be continued. However, if they desire their hospital to meet changing conditions and community needs, hospital authorities, physicians, nurses and medical social workers should begin to concern themselves with three additional aims which logically belong to all hospitals. They are: (1) rehabilitation service, (2) preventive medicine and (3) home medical care. These three additional aims would verily make the hospital a physical and functional facility—set up for a coordinated and complete medical and health service.

Rehabilitation Service

Especially in our own hospital, for example, where the predominant interest is orthopedics, the end result of disease is of special concern. The character and degree or residual disability with which many patients have to live and earn a livelihood, the type of work and the number of hours of work a day suitable for each condition are matters of importance. They are a challenge to the progressive hospital, which it can meet by extending its activities beyond the period required for relieving or curing disease and correcting deformity.

The hospital can enter into the social and economic life and abilities



Rehabilitation in the occupational therapy department. Left: Amputee learns to use her left hand; right: dressmaking.

and aptitudes of the patient in a direct and constructive way by making possible the return to maximum productive capacity after complete or partial recovery from illness or disability. This it can do by a soundly conceived and intelligently applied rehabilitation service.

In our institution, the recommendation to add rehabilitation as a hospital aim has already been initiated. On an experimental basis, the hospital inaugurated a rehabilitation program jointly with the New York City division of the state vocational rehabilitation bureau. The program consists of a coordinated effort of four major departments, namely, clinical medicine, medical social service, physical medicine and occupational therapy.

Together their professional members, aided by a vocational counselor, constituted themselves into teams, each person performing a special task that is complementary to all others. They combine their efforts into a workable program of rehabilitation, aiming at a balance of the physical, psychological and vocational demands of a suitably selected job objective. Thus, people whose lives are threatened with disruption because of disability resulting from illness are prepared and returned to useful work and to earning a livelihood.

The results attained thus far from this experiment have been highly satisfactory and justify the continuation of rehabilitation service as a permanent aspect of the hospital's program of medical care. In fact, it is likely that in the future this service will be enlarged to serve not only ward and outpatients but also such private patients as might be referred by medical staff members.

Preventive Medicine

The hospital is the natural source of plan, program and performance aiming at improvement of the public's health. Out of it should radiate important scientific advances looking toward prevention of disease; from it should come methods of instructing people in the practices of hygiene at home, at school, at work and at play.

Diagnosis and treatment of disease are not enough. The hospital's program should also include such activities as health education, prenatal care, child health, dental hygiene, mental hygiene, nutrition, prevention and control of tuberculosis and venereal diseases, and immunization and vaccination as protective measures against other diseases. The hospital could well be the regional headquarters for health associations; district, visiting and school physicians and nurses, and all others who serve a given population in the interest of disease prevention. The immeasurable resources of the hospital in the field of disease prevention will be realized only when a full program of preventive medicine is added as one of the hospital's aims.

Home Medical Care

The hospital as it functions today in relation to community needs was found in our study of our own situation to be incomplete in its service in another respect. In admitting and treating the average ambulatory and bed patient, the hospital invariably begins its diagnostic and therapeutic service somewhere in the middle of disease or disability. By adding home medical care as one of its activities, it can begin at the beginning and end at the end of disease.

Except for patients suddenly stricken on the street or at work, people first take sick at home. At that point a physician should be available; members of the hospital staff should see to it that there always is one. Early diagnosis means early therapeutic measures. Early recognition of communicable disease and its isolation safeguard the health of family and neighbors. Early and proper treatment lightens the severity and shortens the length of illness.

These factors have an important bearing on the costs of medical care and on loss of earnings. The patient's illness dossier begins at home. If he is admitted to the hospital, it is continued at the hospital, and when he is discharged from the hospital it is further continued in the outpatient service or at home. Should he take sick again after recovery, all previous records are available; they are known to the hospital and its staff and can be an important guide in future diagnosis and treatment.

It is paradoxical practice, insupportable by any explanation, that the poor can receive free or part pay care in hospitals but when they are ill at home in many instances must remain unattended. As low income people learn that their local hospital also provides home medical care rendered by physicians and nurses whom the hospital pays, on the basis of fixed fees per visit or by salaries, they will utilize the service, receive early care and, thus, often avoid prolonged illness. Incidentally, adequate home medical care would reduce hospital bed occupancy, thereby vacating beds for patients requiring and awaiting admission to hospitals.

This is second of the series of three articles by Dr. Golub on the changing responsibilities of hospitals. The final article will appear in an early issue.

VOLUNTEER ACTIVITIES

It's Their First Offense

All will be forgiven, including the name "Kiddie Hour," when the women's guild of White Cross Hospital, Columbus, Ohio, turns over the proceeds from a recent tea and program. Can doting mothers and grandmothers be blamed if on a rare occasion they decide to show off the talents of their youngsters at a public gathering? The children who did the songs, dances and recitations were members of guild families.

This active guild has recently laid out $1192 for removing an old cement floor in the hospital and installing asphalt tile and for cutting by 60 per cent the corridor, lobby and service room noise through the addition of acoustical tile.

Jobs for Juniors

Junior Red Cross volunteers, to the number of 60, have made life at Central Maine General Hospital, Lewiston, much less complicated. At the beginning of fall term of high school, the hospital recruited these workers and to them it has assigned an amazing number of tasks.

The juniors work in the laboratories, business offices, central supply room and occasionally give assistance in routine jobs on the wards or at the admitting office. They deliver mail and flowers as well.

St. Michael's Junior Guild at near-by Auburn manages to turn over $100 or so each year from the "traveling store" which the girls take to the floors twice each week.

A Practical Outline of Personnel Management

DONALD C. EDMONDS
Personnel Director, Alexandria Hospital, Alexandria, Va.

PROBLEMS of personnel management growing out of the war years and pointed up by unusual demands on hospitals of all sizes and types, demands which are continuing and will continue, are spotlighted at the present time in the field of hospital administration.

While it is recognized that hospitals cannot adopt *in toto* without preliminary study the entire program of personnel administration from private industry and government, nonetheless, human beings are human beings with the same wants, urges and motivations wherever they are employed. And while admitting and insisting upon the special relationships which exist in hospitals, it is imperative that we initiate modern personnel technics if we are to compete with private industry for the services of qualified individuals and if we are to retain the services of those qualified persons already in the hospital field.

Hospitals whose size prohibits the employment of a full time personnel director should make a definite assignment of responsibility for their personnel administration to a specific member of the administrative staff, in most cases the administrator or his assistant. Regardless of the organization, however, the following functions are part of any program of integrated personnel management: employment and placement; employe programs and relations; job analysis, evaluation and wage administration; training.

In the event a full time personnel director is employed, he should exercise supervision over the pay roll section inasmuch as the preparation and payment of pay rolls depend entirely upon personnel matters: entering of new employes on duty and their salaries, termination of employment, time cards and sick and vacation leave privileges. This, however, is a matter for the administrator.

Employment and Placement

Employment and placement, if they are efficient, mean obtaining adequate services and placing capable people whose level of ability is neither substantially above nor substantially below the requirements of their position. If individuals are employed to do work which but partly utilizes their education, experience and training, they will rapidly become dissatisfied and resign. On the other hand, people whose ability and background do not measure up to the workloads and responsibilities of the job will not return a dollar's worth of work accomplished for the expenditure of that pay roll dollar.

It is essential that prospective employes should not be "sold" on promotion when they apply for work. Promotion can never take place unless an opening occurs in the institution by virtue of resignation, death or dismissal of a present employe—or unless a department expands and new positions are thereby created. Past hospital records of turnover and contemplated plans for expansion, if any, should govern selection on such a basis. As minimum functions, however, employment and placement should include the following procedures:

1. Make a detailed description of each position vacancy and an appraisal of each based on mental ability, skill and experience and physical requirements.

2. Centralize procurement of all applicants from advertising, employment agencies or offices, the local U.S.E.S. and from those who apply voluntarily.

3. Have a frank interview with all applicants, including administration of whatever employment tests are desired, and remember the three purposes of any personnel interview: "To get information, to give information and to make a friend."

4. Refer only properly qualified applicants to departments for final decision.

5. Check applicant's references. Reference replies should not be given primary weight except for verification of applicant's former positions and the contents of such duties, including salaries. General human tendencies to give former employes or friends a good start on a new job make discounting of replies from references mandatory.

6. Upon approval of employment, process applicant, *i.e.* confirm salary rates and working hours, starting date of employment, sick and vacation privileges, delivery of employes' handbook and completion of withholding tax form. Notify pay roll section of pertinent data concerning new employe and send locator card to main switchboard (name, address, telephone number, department and position).

7. On initial day of duty have new employe conducted on tour of the hospital.

8. Within a week of employment, have informal interview with new employe and, separately, with his supervisor concerning his work and progress.

9. Publish and maintain a policy that all hospital vacancies will be filled by promotion of present employes if they are qualified.

10. Inherent in these requirements are the preparation and use of an adequate application-for-employment form. Statements as to past positions and their actual duties and responsibilities should be required, as well as salary information.

Employe Programs and Relations

Employe programs and relationships are of the highest value if management is to ensure the continued efficiency of the individual employe. The following programs deserve consideration:

1. The initiation and administra-

tion of a semiannual system of employe merit ratings or progress reports.

2. The initiation, publication and administration of an adequate system for hearing and reviewing legitimate employe grievances by immediate supervisors, department heads and the personnel director, in turn.

3. The accomplishment of exit interviews with all employes leaving the pay roll and coordination with department heads in correcting those irregularities which thereby may be discovered to exist.

4. Some system for rewarding and publicizing long, faithful and meritorious service on the part of individual employes, possibly by the awarding of small pins or emblems at mass employe meetings semiannually.

5. Initiation and administration of an employe suggestion program. Individuals will grow closer to the institution if they feel their ideas are appreciated and the hospital itself may receive some helpful suggestions which will save money, supplies or personnel.

6. Making some provision, if a full time personnel director is not employed, for individual problems of employes to be heard and assistance rendered. These would not include employe grievances but such matters as income tax, housing, transportation or personal problems.

7. An employes' handbook should be prepared and distributed to each individual worker and each new employe. Matters covered will vary but should include minimum wage policies, sick and vacation privileges, leaves of absence, grounds for discharge or dismissal, policy for filling position vacancies, sick and hospitalization rights, pension plan, insurance plan, grievance procedure and other matters too numerous to mention, including pertinent information about the community. These books may include statements of hospital departmental functions although it is suggested that separate publications be maintained along functional lines as desired.

Job Analysis, Evaluation, Wages

Job analysis, evaluation and wage administration together with sick and vacation leave privileges are too broad a subject to be completely covered in this brief article. Hospitals that desire to install modern systems are referred to many studies concerning the two major programs in current job evaluation: the point system and the factor or ranking system. In general, however, in beginning a job evaluation program including analysis and wage administration, the following points should be covered.

1. Include all positions up to an arbitrarily decided level of work or salary. Department head and major positions are matters for individual arrangement, but do not exclude any positions below the level of work which you yourself have arbitrarily chosen.

2. Analyze and evaluate all positions on the same basis: mental and educational, skill and experience and physical requirements.

3. Prepare and maintain organization charts to determine and to compare comparable position responsibility.

4. Do not confuse a statement of goals with work being currently performed.

5. The job description itself should be simple and should be prepared by the *individual worker* and approved by the department head. He should list a detailed statement of what his job is and how he does it, including names and positions of persons supervised. He should include special physical conditions or requirements of his position and indicate in per cent the relation of each portion of his job to his entire working day. He should state which duties occur daily or frequently and which are rarely necessary, and he should tell which portion of his work he considers the most difficult and why.

Before completing this form the employe should be informed of the purposes of the survey: (a) to compare and determine his level of responsibility and duty with those of all other employes and to rate them impartially in dollars and cents; (b) to prepare a manual of job specifications for use in employing and placing personnel. When the employe has finished, space should be provided on the form for the immediate supervisor to agree or disagree with the description, duties and responsibilities so outlined and the reasons. Finally, the department head should approve the form and space should be provided for him to make a statement as to the minimum level of education, experience, training and skill necessary to perform the duties so outlined *not in respect to the individual presently occupying the position* but merely in relation to the duties and responsibilities *of the position itself*. The last is for assistance in preparing a hospital manual of positions and their specifications for use in employment and placement as well as in job evaluation and wage administration. All job descriptions and analyses should be reviewed at least twice a year because jobs often change.

6. The subject of sick and vacation leave is presently a confused field. While this is merely a suggested goal, compensate employes in dollars and cents, not in sick and vacation leave. Lower salaried employes may need as much vacation or sick leave as your top salaried people. Vacation leave, of course, should be based on the employment year, not on the calendar or fiscal year, with vacations not mandatory except between May 31 and September 30. Some preliminary period of employment should be required before an employe is eligible to take leave although he should earn such leave from his initial date of employment. Neither sick nor vacation leave should accrue beyond a reasonable period.

Training

The personnel department or person assigned with the personnel responsibility should be charged with coordination of all training necessary to fill the hospital's needs and the specific responsibility of all employe and supervisory training, either on-the-job or such courses as employe relations, how to supervise, how to instruct and other basic training programs. The chief nurse, however, should still be responsible for the administration of such training programs as are properly hers.

Personnel management is a personalized and technical field, the development of which is comparatively recent. With a substantial and major portion of the hospital operating dollar going for personnel costs, however, it is a genuine requirement for adequate hospital administration. Personnel administration to be effective requires trained personnel with a real knowledge of people and technics but will pay its own way in decreased employe turnover, better procurement of workers and increased employe efficiency. It deserves the closest attention of all hospital administrators.

SMALL HOSPITAL FORUM

Purchasing Practices and Policies

THE administrator is the purchasing officer of the small hospital, a survey of purchasing practices and policies in a group of institutions ranging from 25 to 125 beds reveals. The average size of the institutions surveyed was 80 beds. Of course, some delegation of actual purchasing routines exists in these hospitals; especially, dietitians take over the day to day purchases of food supplies in approximately one third of the hospitals in the group. Generally speaking, further delegation of buying authority occurs only in the larger of these hospitals.

Only two of the hospitals have purchasing agents. Both are in the 100 bed group. A third hospital is connected with a university and uses the services of the university's purchasing agent.

In five of 18 hospitals surveyed, the administrator does all the buying, the small hospital forum revealed. In six hospitals some of the purchasing duties are shared by the dietitian and in seven institutions departmental purchasing, at least of some supplies, is permitted.

In two of the 18 hospitals reporting, members of the medical staff purchase supplies or equipment. This is not to say, however, that staff members are not consulted on such purchases, or that their wishes are not invariably respected. The survey had to do only with actual purchasing.

In individual instances, such executives as the nursing superintendent, laundry manager, operating room supervisor and pharmacist make purchases for their departments.

In all but two hospitals of the entire group, the administrator was named as the person who purchases hospital equipment, as differentiated from supplies.

Not many items in these hospitals are purchased on annual contracts based on consumption estimates, the reports indicate. Fuel is purchased on contract at seven hospitals, for example. Other contract items are: certain lines of drugs in four hospitals, surgical gauze products, also in four, textiles in two hospitals and canned goods in one.

About two thirds of the hospitals make a systematic effort to estimate needs and purchase supplies in advance, at least on major categories of purchase. The others have no established practice or policy governing advance purchases.

Actually, there is no real, hard and fast line between these two groups of hospitals—those which purchase according to plan and those using somewhat more casual methods. Instead, it is plain, hospitals are likely to estimate needs carefully on four or five lines and not on others. The two thirds-one third division is an estimate from the reports of purchasing practices in these hospitals, as indicated in the accompanying table.

In purchasing equipment, 11 of the reporting hospitals always get competitive bids. Most of these do so without reference to the amount of the purchase, although one or two reports indicate that bids are sought only when the purchase is for equipment costing more than $500, or more than $1000.

Among 10 hospitals indicating that the routine of purchasing varies with the size of the purchase, two report that the board of trustees approves high-cost purchases and one has a purchasing committee which looks over large purchases. In six cases, the approval moves from the departmental to the administrative level when the order reaches a given figure, and one hospital reports frankly that the routine varies according to the amount of cash on hand at the time of the purchase.

Not a single hospital in this group has anywhere a written statement of the hospital's purchasing practices and policies, although one administrator reported that such a list of purchasing regulations was being compiled at the time the survey was made.

In one of these hospitals, suppliers' salesmen are interviewed by appointment only. In all the others, there are no specific rules governing interviews with the trade, and several added the comment that they are "always glad to see the salesmen who represent reputable hospital supply companies."

Periods for Which Purchases Are Made In 15 Reporting Hospitals*

HOSPITAL	TEXTILES	SURGICAL GAUZE	NEEDLES AND SYRINGES	DRUGS	FUEL	CANNED GOODS	STAPLE GROCERIES
1	6	3	6	12	12	1	½
2	3–6	12	+	12	12	+	+
3	6–9	4–6	4–6	12	12	6	¼
4	12	3	3	1½	12	2	1
5	12	3–6	6	3–6	1	6	1
6	+	+	+	12	+	+	+
7	6	+	+	3	12	12	1
8	1	1	1	1	1	1	1
9	3	3	3	1	12	1	1
10	+	+	+	12	+	+	+
11	+	+	+	+	12	+	+
12	+	12	+	+	12	+	+
13	+	12	+	+	12	+	+
14	12	12	2	1	1½	3	1½
15	6–12	3–6	3	+	+	3–6	+

*All periods stated in months.
+Not stated.

ABOUT PEOPLE

Administrators


Dr. Mackenzie

Dr. John C. Mackenzie, formerly general superintendent of Montreal General Hospital, Montreal, Que., has been named administrator of Touro Infirmary, New Orleans, to succeed **Dr. Lewis Jarrett.** Dr. Mackenzie interned at Montreal General in 1928-29 and served in the admitting office of the hospital the following year. He was made assistant superintendent in 1930 and then became head of the institution in 1931. During the war he served in the Royal Canadian Medical Administrative Corps, with the rank of lieutenant-colonel. After he left the army, Dr. Mackenzie was a hospital consultant. He is a fellow of the American College of Hospital Administrators and holds membership in the American Hospital Association, the Canadian Hospital Council and the International Hospital Association.

Dr. Madison B. Brown has been named first assistant director of Johns Hopkins Hospital, Baltimore, to succeed **Dr. Russell A. Nelson.** Dr. Nelson will devote his full time to the position of director of medical clinics at the hospital. Dr. Brown was formerly assistant director of Roosevelt Hospital, New York City.

Mrs. Calista Fulkerson, R.N., formerly superintendent of Douglas County Hospital, Omaha, Neb., has been appointed assistant superintendent of Butler County Memorial Hospital, Butler, Pa.

Lt. Col. Richard R. Brady, a graduate of the University of Nebraska College of Medicine, has been named supervisor of administration of all United States army hospitals in Germany and Austria, with headquarters in Frankfurt, Germany.

Herman J. Fishman has been appointed business manager of Cedars of Lebanon Hospital, Los Angeles, to fill the position left vacant by the resignation of **George Hohenstein.** Mr. Fishman was graduated from New York University in 1935. His previous experience has included five years as a practicing public accountant, two years as business manager of Sydenham Hospital, New York City, and four years' service in the army.

Norman L. Losh has resigned as director of Riverside Hospital, Toledo, Ohio, to become director of Orange Memorial Hospital, Orlando, Fla. He took over his new duties on December 1. Mr. Losh joined the Riverside Hospital staff in 1944, coming from Northwestern University where he had been taking postgraduate work. No successor to Mr. Losh has been determined upon but the board of directors announced that **Melvin J. Arnold,** hospital purchasing agent, will become assistant director.

Robert L. Griess has been named assistant to the superintendent of Presbyterian Hospital of Pittsburgh. He was formerly purchasing agent for the Presbyterian and Woman's hospitals. At the same time announcement was made that **Virginia Ferris** was named purchasing agent of the institution.

James L. Dack, former administrator of Community Hospital, Battle Creek, Mich., was recently appointed to direct the Michigan State Hospital Survey and Construction Program. Before going to Community Hospital Mr. Dack was administrator of South Haven Hospital, South Haven, Mich., and was employed in the hospital division of the W. K. Kellogg Foundation at Battle Creek. He received his master's degree in hospital administration from the University of Chicago.

Richard C. Leavitt has been appointed superintendent of United Hospital, Port Chester, N. Y., succeeding **Carl Wright Jr.** whose resignation was recently announced. Mr. Leavitt has been associated with the hospital for five years as chief accountant.

Mrs. Julius Savit, for eighteen years executive director of the Orthodox Jewish Home for the Aged in Chicago, is retiring. She will be succeeded by **Jacob G. Gold,** formerly assistant to the executive director of the Brooklyn Hebrew Home and Hospital for the Aged, Brooklyn, N. Y.

Henry L. Goodloe has been named superintendent of Passaic General Hospital, Passaic, N. J., succeeding **Margaret A. Wallace** who has retired. He was formerly director of St. Luke's Hospital, Newburgh, N. Y.

James H. Murphy has been appointed administrator of Bayonne Hospital and Dispensary, Bayonne, N. J.

Dr. Samuel W. Hamilton, formerly with the United States Public Health Service in Washington, D. C., has succeeded **Dr. Guy Payne** as superintendent of Overbrook Hospital, Cedar Grove, N. J. Dr. Payne recently retired after forty-four years of service.


Dr. Eliot

Dr. Charles F. Wilinsky, director of Beth Israel Hospital, Boston, was named president-elect of the American Public Health Association at the organization's seventy-fifth anniversary meeting. **Dr. Martha M. Eliot,** chief medical consultant of the United Nations' International Children's Emergency Fund, was inducted as president. She is the first woman ever to hold the office.

Dorothy T. Folta has resigned as superintendent of the New Milford Hospital, New Milford, Conn., to become superintendent of the Knox County General Hospital, Rockland, Me.

Michael S. Grobsmith has resigned as night superintendent of the Jewish Hospital of Brooklyn, N. Y., to assume the position of assistant director of Lebanon Hospital, New York City.

H. N. Lovig is the new superintendent of St. Luke's Hospital, Newburgh, N. Y. He was formerly head of Carson C. Peck Memorial Hospital, Brooklyn, N. Y.

O. K. Fike, administrator-director of Miami Valley Hospital, Dayton, Ohio, has resigned from that position, which he has held for four years. Mr. Fike was formerly head of Doctors Hospital, Washington, D. C.

Dr. Jacob Horowitz has been appointed assistant director of the Israel Zion Division of Maimonides Hospital of Brooklyn, N. Y. He is a graduate of the school of hospital administration of Columbia University.

Harry C. F. Gifford has been appointed assistant to the superintendent, Hackensack Hospital, Hackensack, N. J. A graduate of the course in Hospital Administration at Columbia University, Mr. Gifford joined the Greenwich Hospital, Greenwich, Conn., as administrative intern, remaining as assistant to **William J. Donnelly,** superintendent. He assumes his new duties January 1.

O. H. Overland has resigned as head of Grand Forks Deaconess Hospital, Grand Forks, N. D., to accept a position with the hospital's board of trustees as solicitor of building funds to raise $750,000 to finance a new 100 bed addition

(*Continued on Page* 164.)

TRUSTEE FORUM

CONDUCTED BY RAYMOND P. SLOAN

Who Are our *Hospital Leaders?*

RAYMOND P. SLOAN

Photograph by Sarg-Taylor, N. Y.

William Harding Jackson, president of the New York Hospital; chairman of the Hospital Council of Greater New York, and chairman of the United Hospital Fund campaign for 1947

IT IS possible that William Harding Jackson has proved as much of a surprise to those who appointed him president of New York Hospital back in 1940 as he has to himself. When a year prior to that time a friend approached him on joining the board of that venerable institution, the young lawyer from Tennessee who had come to New York to make his way never had a thought of hospitals or hospital work. He was far too engrossed in his own law practice and the tremendous amount of research it involved. "Do you mean Cornell, that building way over on the East Side?" he had asked in unpretended innocence.

If he had never thought about hospitals before, he started to do so then and has been thinking about them ever since. The same social consciousness that characterizes his thinking and planning today prompted him to accept. Immediately he felt himself less akin to research and more concerned about medical and hospital care in American society.

Others, recognizing this sense of social responsibility in the young attorney from Tennessee, urged him later to accept the presidency of the institution. It was the beginning of that period when hospitals felt the need of new and younger blood on their boards. They had even begun to acknowledge that women might have a contribution to make.

In his thoughtful, unassuming manner, but with the keen mind of the lawyer at work, Jackson began to look around him and draw certain conclusions. Always he listened closely during the frequent consultations he held with those in whose knowledge of hospital and medical affairs he had confidence. Always, too, he did his own thinking.

The results of this process of indoctrination into the hospital world were apparent in the remarks that were made in 1941 by this president of New York Hospital before the forty-third annual convention of the American Hospital Association in Atlantic City. It constituted his debut before a hospital group. His subject was "Educating the Trustee," and his definition of the functions of a trustee based principally on his own experience created a profound impression. There was novelty even, at that time, in the fact that a hospital trustee should recognize his own limitations.

Said Jackson: "The function of the hospital trustee is to decide on the important questions of policy that arise out of changing circumstances and conditions in such a way that the major purposes of the hospital can be steadfastly pursued. To the extent that the trustees who make these decisions are specifically informed, and in the broad sense educated, the hospital's course will have direction toward the goal of complete and more useful service.

"This does not mean that a board of trustees should attempt to administer the business work of a hospital. That is the job of the administrative staff. Nor should the board of trustees interfere in the medical work of the hospital. A meddlesome trustee is worse, perhaps, than no trustee at all. But the board of trustees must ultimately determine the delicate balance between administrative and medical work and must decide finally between conflicting advice on the policies to be followed. The efforts of the board of governors should be directed toward the attainment of an ideal in organization where administrative detail rests with the administrative staff and where the doctors can work with the minimum of interference and restraint, in accordance with constantly revised and developing plans for improved service for the sick."

Following this event, the New York Hospital's plans, like all others, were necessarily laid aside. The whole world became sick, gravely sick, and Bill Jackson with millions of others joined the armed forces. Attaining the rank of colonel, he served as Deputy Chief of Intelligence on Gen. Omar Bradley's staff.

As he served, he continued to observe, to study the reaction of American soldiers and to think. That war was educational to our men he recognized, but its most marked manifestation was the soldier's awakened social consciousness, his clearer realization of social responsibility. Jackson returned with other fortunate ones, more deeply aware than ever of the individual's duty as a citizen of a free society to work toward the solution of certain problems with an attitude of unselfishness and with the deepest concern for the general welfare.

He soon found himself farther removed than ever before from the legal research of a lawyer's office. He wanted to play an important part in some of the challenges faced by modern society. His business and professional affairs permitting him more time, he took off his coat and went to work. Today hospital and health matters are a major concern to him.

Heads United Hospital Fund

Again he is president of the New York Hospital, which in itself is a sizable job. When it became evident that the United Hospital Fund of New York would require a greater sum than ever before to meet the deficits of the city's voluntary hospitals, some $2,383,887 to be exact to help defray a combined operating deficit of nearly $4,500,000, it was conceded that there was just one man who could give the campaign what it required, and that man was Bill Jackson. He was ready, and with several weeks yet to go, it looks as if the goal of the campaign would be reached.

Soon a longer term hospital job presented itself which also required leadership—chairman of the Hospital Council of Greater New York, whose study for the overall planning of hospitals in greater New York was released last spring. Again, Jackson, recognizing the challenge, accepted.

Jackson believes in having a goal, the right goal. Here briefly is his. "What I want to see triumphant in America is a modern liberalism, combining the old suspicion of concentrated power with a new feeling of social responsibility, a reawakened faith in Christ's doctrine of the brotherhood of man. This combination can preserve freedom and provide the social conscience to meet human needs."

He is exerting his leadership along these lines. He doesn't believe, for example, that the average man knows what a voluntary hospital is. Speaking before the opening dinner of the United Hospital Fund campaign in October, he declared: "The term voluntary is not always clearly understood and, in any event, does not seem to me to be truly descriptive. A voluntary hospital is not a federal, state or municipal hospital and it is not a proprietary or private hospital run for profit. Voluntary hospitals are nonprofit hospitals. These hospitals might properly be called the free hospitals, not only free in the sense of caring for a large proportion of their patients regardless of their ability to pay, but free from absolute dependence on government; free to avoid bureaucracy and politics; free to investigate in the whole field of medicine; free to experiment in the better organization of medical care; free to accept the chance as they have in the past, to lead the way in medicine."

Such interpretation of hospital services needs to be brought to the attention of the community, every community, Jackson contends. The people need to know the facts.

It is for this same reason—to get more people interested in hospital services and needs—that he believes in large boards. Thirty is not too many, provided the board is comprised of younger men principally. "Let the young men do the work," is his motto. For this reason he would make honorary members of all trustees over a designated age limit. And the men who do serve should give in either time and work, money or prestige. "We have need of all types."

Two points are essential in appointing trustees, according to the Jackson plan. "Get the proper men, women, too, for that matter, while they are young, always exercising the greatest care in their selection." At the present time there is one opening on the board of the New York Hospital, for which there are dozens of candidates willing and able to serve. In the operation of large hospitals, particularly, Jackson sees great advantages in having a paid secretary and treasurer as part of the administrative organization.

He concedes no problems in getting board members to attend meetings, even when as many as 30 people are involved. It all depends upon the conduct of the meeting, also whether or not those participating believe wholeheartedly in the thinking and planning behind the project.

The trustees of New York Hospital believe in what Jackson stands for. They agree when he says, as he did before last year's graduating class of Cornell Medical College:

"The merest glimmering of social consciousness demands that society provide every man, woman and child with preventive and curative medical care based on need and regardless of ability to pay. We are, of course, deficient in doctors, nurses, technicians and in medical buildings and equipment. But the essential deficiency is the deficiency of organization. American society has not yet seriously tried to remedy this situation. I am not proposing blueprints, although there are many in existence, for better organization and more extensive medical care. I should prefer to see the solution rise up from the bottom rather than be imposed from the top. It might begin in voluntary hospitals and their diagnostic clinics, extend through group insurance, prepaid medical care and group practice to city, county and state supported hospitals and clinics to the final uncovered area of necessary federal action. I should deeply regret the end of private medical practice and I do not believe that private practice should be precluded any more than public schools or state universities now preclude the private school or private endowed college. But the necessity of adequate medical care for everyone in America must be met in one way or another by society as a whole."

Can Voluntarily Cooperate

And more recently before the United Hospital Fund: "We must prove that free citizens in a democracy can voluntarily unite and cooperate in a system which will preserve the progressive methods of individual initiative and also achieve the advertised equality of state controlled medicine."

They listen and they agree—to their own surprise, perhaps, also to the surprise of Jackson himself, who eight years ago was deeply enmeshed in his law books without ever a thought of one day becoming a hospital leader.

The Answer to Staff Organization

rests largely with the administrator

MOIR P. TANNER
Superintendent
Children's Hospital
Buffalo, N. Y.

NOT only must the administrator of any hospital be the liaison between the governing board and the staff but it is his duty to lead the way in providing hospital care of which his community can be proud. In order to do this, complete cooperation of the staff is essential. In no other way can any of us administer our hospitals properly.

It seems hardly necessary to reiterate the fact that the administrator should attend all staff meetings. He should go farther than this. He must enter actively into the discussions that take place and, to a large extent, steer these discussions into the channels of hospital policies that spell better care.

Worse Than No Conference

The staff conference, which is a requirement for approval by the American College of Surgeons, can be a stimulating experience to both the staff and the administrator—or it can be a farce. Many of us have attended a conference wherein a case or two is read by one of the doctors following which there is little or no discussion because staff members do not want to hurt anyone's feelings. This is worse than no conference at all.

Here is a definite job for the hospital administrator. He knows why this discussion is of little value and it is squarely up to him to start the conference on the right path. Here is the place for him to put into force the requirements that a good hospital must follow; here is the place for him to interpret the real meaning of a medical audit.

A well trained administrator knows whether the proper laboratory procedures are being accomplished in his hospital and no staff can give him a valid argument against these laboratory procedures. If patients are being sent to surgery without a proper work up, it is a matter of record. Such a situation cannot exist if the requirements of good hospital care are followed.

When the administrator points this out to the staff, he is certain to hear the well known arguments that these requirements of standardizing bodies are foolish and meaningless; they may be all right for the large city hospitals but they do not apply to the community hospital. If the name of the hospital does not appear on the approved list of the American College of Surgeons, however, the same doctors will undoubtedly be the first to accuse the administrator of negligence and inefficiency.

What is more, the governing board is quite likely to take the same attitude. This is just as much the governing board's responsibility as it is the staff's, perhaps more so, and it is just as much the job of the administrator to receive from the governing board authority to put into force these fundamentals of good hospital care. To be sure the governing board may not know whether or not the laboratory facilities of the hospital are adequate, but the administrator knows, and more than anyone else he must see that they are. What good is a hospital without these facilities? This is equally true of the x-ray laboratory, pathology laboratory and all other clinical departments of the hospital.

It must be admitted, however, that no superintendent, whether the administration of the hospital is medical, nurse or lay, can do these things without the complete cooperation of his board and staff. They have to be convinced of the necessity not only of the formation of departments but of more nearly complete departments, properly equipped and staffed, which will provide better medical care for the patient. The administrator must do this educating.

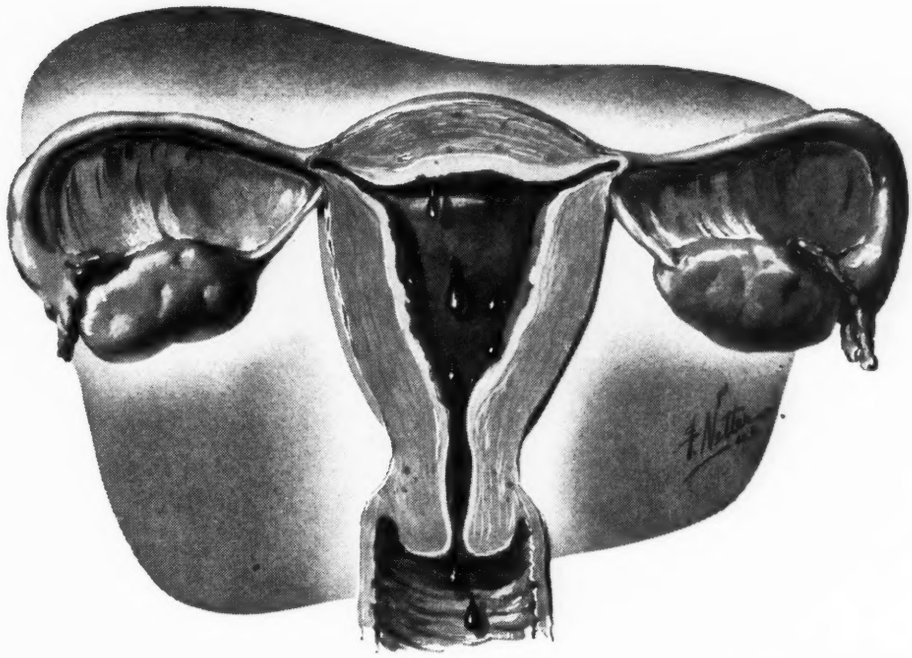
Many of us have talked with administrators who seem to consider it unnecessary to have a resident or an intern in their 125 or 150 bed hospitals. This cannot be the administrator's point of view. Could it possibly come from the staff?

Essential to Good Care

Some hospital superintendents have stated that often the staff does not want to take the chance of having more physicians settle in the community. This is difficult to believe. Simply because a resident might like the community and stay, there is little reason for denying that community this necessary detail of hospital care. In our own locality no hospital in the adjoining eight counties can boast of a house officer except hospitals located in Greater Buffalo.

It is a matter of public record that of the 11 member hospitals outside the city of Rochester, N. Y., only one 275 bed hospital had a resident staff prior to the formation of the regional hospital council. The obvious value of such a service prompted the council to undertake a program of rotating interns from the large city hospitals to the community hospitals for a period of from one to three months. This plan is now in operation and has the approval of the Council on Medical Education and Hospitals of the American Medical

Presented at the meeting of the New York State Hospital Association, 1947.



Functional Uterine Flooding

Some years ago it was noted that the administration of some crude liver extracts for treatment of anemia in cases with excessive uterine bleeding produced a lessening of the flow. This led to the isolation of an active anti-menorrhagic factor from the sterols of the liver. Very good results have been obtained from the use of this ANTI-MENORRHAGIC FACTOR (ARMOUR) in the control of functional uterine bleeding. Such bleeding is most common in patients approaching the climacteric or during adolescence but it may occur at any age. Usually it is menorrhagic in type but may be intermenstrual or metrorrhagic. There may be complete irregularity in the menstrual function. ANTI-MENORRHAGIC FACTOR (ARMOUR) is recommended in all these varieties provided there is no underlying organic factor such as tumor.

During excessive flooding massive dosage may be indicated—8 or more glanules t. i. d., up to 50 per day. The most advantageous time to start treatment, however, is about two weeks before menstruation, giving 2 or more glanules t. i. d.

Literature upon request.

Anti-Menorrhagic Factor

ARMOUR

Have confidence in the preparation you prescribe—specify "ARMOUR"

THE Armour LABORATORIES

HEADQUARTERS FOR MEDICINALS OF ANIMAL ORIGIN • CHICAGO 9, ILLINOIS

Association, the New York State Department of Education and the Veterans Administration for veteran interns. There seems little doubt that approval will be granted to rotate second year interns on the same basis.

Is it possible that there can be a financial problem here? There is no doubt that the house officer in a community hospital can learn a great deal of medicine and can be of inestimable value to the community that hospital serves.

The already overburdened administrator cannot stop here. He should make an effort to obtain staff members who are certified by their respective boards and convince the staff of the advisability of placing them in charge of the various specialties in the hospital. If this is impossible, he should strive to obtain staff members who are in a position to be certified. These improvements must originate with the administrator, receive the approval of the governing board and be put into operation by the staff.

Staff Must Agree

Let us look for a moment at the age old problem of records. Are we insisting on good records? If we have physicians on the staff who will not provide adequate progress notes, who will not sign their records, it is almost a certainty that no one will do anything about the problem unless the administrator does it. He takes the matter to the staff, which obviously agrees; it can do nothing else. So a rule is made that physicians who do not comply with these staff regulations will be denied the facilities of the hospital for their patients. The governing board confirms and approves this procedure and must enforce it.

We have all seen the "curbstone conferences" of the staff and board members which result in the decision that some doctor is too busy to complete his records and should not receive the full penalty for his negligence. That sort of thing must not happen if the hospital is to provide the type of care that every community is demanding.

The task of organization is not easy. It is not a job for an administrator who is controlled by a board member or a group of board members, or for one who is controlled by a few staff members. It requires not only the knowledge of good hospital care, not only firm organization of staff and board, but the stamina to stand back of these decisions and enforce them.

Another phase of this problem is that staff members, if they are to be of maximum value to the hospital, must know more about that hospital. We have told them so little that many of them do not realize the importance of standards. They have no reason to change the routine they have been following for many years. They feel that their first responsibility is to their private practice, while their hospital struggles along as best it can with little or no help from them.

At every opportunity the administrator should tell the staff the hospital's problems, the deficits for the month, where costs are rising and why, and problems of organization. It would also seem wise to compare the medical standards in the hospital with those of other institutions, showing the deficiencies under the broad light of comparison.

Every staff is organized into committees. The administrator needs to attend every meeting of each committee and direct its efforts. Committee recommendations should go to the executive committee of the staff and to the governing board for final approval.

The rapid advances in laboratory procedures, methods of diagnosis and special equipment for diagnosis and therapy mean that more and more competent personnel is required. These technicians are invaluable aids for the physician and every community deserves them. They are, of course, valueless unless properly directed by the physician or surgeon. Every community hospital cannot have every new item of diagnostic equipment at its finger tips. That is why we have such organizations as the regional hospital council. The progressive community hospital administrator will urge a formal tie-up between his hospital and an existing medical center so that the best equipment and personnel will be available to patients in his community.

The staff must realize in this day of approved standards that the administrator cannot be a policeman; governing boards must realize that every physician is not qualified to do every medical and surgical procedure. This becomes a matter of organization. As medicine becomes more concentrated in our hospitals, we must assume more and more our full responsibility to our patients. This is true for all of us, staff, board and administrator. We can clearly see the necessity of forgetting any differences, professional or otherwise, that may exist and working together to establish policies and maintain control of the quality of medical care.

One prominent administrator pointed out recently that, while there is this need for individual hospitals to join forces, there is even greater need for the medical and hospital organizations to work more closely together with a real understanding of each other's problems and responsibilities toward improving medical care in hospitals. Until this is done, the only one who will suffer is the person whom the doctor, the board member and administrator all profess to serve—the patient.

Fails to Give Authority

In too many cases the board holds the administrator responsible for standards yet fails to give him the authority to maintain them. Many times the administrator is in an impossible position as regards staff relationships. Certain hospitals with a record of long and distinguished service have fallen from public favor because they did not keep their medical house in order. Keeping the house in order requires sound organization and a thorough understanding of the administrator's position in that organization. We must get away from the theory that all a hospital needs is a hotel man or an experienced business executive.

One of the journals recently presented a survey showing the number of hospitals of various sizes with special departments. It was appalling to note the number of hospitals that do not possess seemingly essential clinical departments. This would indicate inadequate organization and certainly an improper relation of the administrator of the hospital in that organization.

There is nothing in this discussion of staff organization that most of us have not known for years. There is no need to take the attitude that nothing can be done about it, for something must be done in the near future. The answer rests largely with the administrator.

Medicine Faces New Challenges

JOHN W. SHERRICK, M.D.
Peralta Hospital, Oakland, Calif.

THROUGHOUT the years American medicine has forged steadily ahead, until today it is the finest in the world. This advance has grown out of the vision, the courage, the sacrifices, the unrelenting toil of American physicians. Pacing and conditioning this unprecedented medical progress have been several factors which still form a code for medical men and women everywhere.

These factors may be outlined as: (1) a stern sense of personal honor, integrity and responsibility; (2) a belief in the dignity of man; (3) a determination to serve mankind and to serve it well; (4) a code of ethics which is given expression in the oath of Hippocrates and which has guided, and continues to guide, the acts of medical men and women; (5) the formation at varying levels of medical organizations whose aims are both scientific and social, designed to promote the temporal interests as well as the health of the American people.

Contributions to Society

Accompanying the growth and the progress of American medicine and forming an integral part of them have been the many contributions to society by members of the medical profession. These men and women—unselfish, honest, sincere, courageous—form a chosen group. They are highly trained. They are conscious of the challenge peculiarly inherent in medical and surgical problems. They have accepted, and will continue to accept, their responsibilities, in response to which it is their determination, first, to continue to serve honorably and well at all times; second, to correct imperfections and mistakes that may arise; third, to search out the unknown.

Amazing accomplishments have accrued throughout the years, the result of many diverse and divergent factors and influences. New technics have been developed, new knowledge and understanding have been made available, equipment has been perfected, diagnostic procedures have been worked out and effective methods of therapy have been clarified.

However, the end is not yet. Many and greater problems remain. The challenge still persists, a challenge that is clean cut, inspirational and worth while, and that has been, and will continue to be, met with enthusiasm. Such an approach is wholesome and stimulative and pays good dividends. But now the challenge assumes a subtler, a more critical, a destructive tone. It poses for medicine a grave problem. It finds expression, on the one hand, in the implied criticism expressed by the proponents of compulsory health insurance, who argue that adequate medical care is beyond the economic possibility of a large section of our population and would therefore change the whole system of medicine.

On the other hand, criticism of the medical profession is open and direct. While admitting that American medicine is the finest in the world, it charges medical men and women, and surgeons in particular, with inadequate training, ignorance and neglect of the psychoneurotic aspects of ill health, incompetency in diagnosis and in surgical technic, overzealousness in operating, a desire for monetary gain and fee splitting conspiracies.

Sober consideration and honesty compel us to grant that faults and inadequacies do exist in medicine and will continue to arise, as they do in any profession or trade group. Yet if we would be true to our medical code of ethics, if we would keep faith with the changing order in medicine, if we are sincere in our determination to avoid deterioration of the health of the public and of the science and practice of medicine and to provide for all people at all times the best medical care possible within their economic limits, we must assume the burden of righting these and all other wrongs that may arise. Further, we must continue our efforts to solve medical and surgical and health problems now existent and any that may arise in the future. Preventive medicine, voluntary health insurance *versus* government subsidy plans or compulsory medical insurance, extension of public health services, expansion of research, improvement of medical education in all its phases, development of group medical practice—these and other questions must command our keenest efforts.

Continue and Expand Program

These things can be accomplished in part by continuing, expanding and perfecting the methods outlined. To keep pace with the program of adequate minimum training and experience now requisite for certification of the various specialty groups, we must place emphasis upon higher qualifications, better grooming in basic foundations and adequate graduate training for the general practitioner and for perfecting the organization of smooth cooperation between him and specialists. Thus the general practitioner can better carry out his duties as the family doctor—an enviable and honorable position; the specialist can complement him, as he ought to do, and the patient can receive the optimum in quality, efficiency and economy of medical service.

Emphasis must be placed, too, on the patient as a biologic unit, on the beginnings of disease, on health guidance as well as on diagnosis and treatment, on mental as well as physical health.

Too, there is posed for us the problem of public relations. A good public relations program for medicine presents two basic demands: (1) the presentation of a good product which must be equitably marketed; (2) constant appraisal and supervision of medical and surgical procedures with strict self discipline as a protection for the members of the medical profession and for the public.

With perfection as our goal, we must be constantly on the alert to improve the quality of medical care and to prevent inequities and incompetency. Measured by the procedures outlined, many medical groups throughout the United States are doing an excellent job in carrying out procedures to elevate the standards of medical and surgical care and of preventive medicine. But we must admit that others are definitely not.

None of us is perfect and inequities and irregularities may exist. Such irregularities and inequities must be eradicated in order that we may present to the public an unchallengeable front. It is imperative, too, that we must enlist the full confidence and the loyal and friendly cooperation of the public, including the vociferous minority group of present day critics of medicine. To that end, the public must be taken into our confidence and informed of the aims and the accomplishments of medicine and of the measures that are being utilized to improve medical care and to correct existent faults.

Finally, we believe in free enterprise that is fully cooperative and that is curbed and disciplined by government only when it runs counter to the general welfare.

Let's look at the record, but let's be sure that it is free of faults.

NOTES AND ABSTRACTS

Prepared by the Committee on Pharmacy and Therapeutics, University of Illinois College of Medicine, Chicago 12

New Methods in the Study of the Physiology of the Kidney

AS IS well known, the functions of the kidney are primarily to rid the body of waste products and to assist in the maintenance of normal acid-base and water balance. Urine formation results from a complex interplay of many factors operating in dynamic equilibrium. The cardiovascular system is all important for normal kidney function in that it supplies a constant blood flow at a maintained head of pressure. Approximately 20 to 25 per cent of the cardiac output goes through the kidneys each minute. During a twenty-four hour period, approximately 1,800,000 cc. of blood flows through the kidneys. This is equivalent to 500 gallons of fluid. From this huge volume of blood, the kidneys produce approximately 190,000 cc., or 211 quarts, of filtrate. They then proceed to reabsorb 188,000 cc. and finally excrete from 1500 to 2500 cc. of concentrated urine.

The control of this wonderfully complex mechanism is divided among many interested parties. The central nervous system, the cardiovascular system and the endocrines are the major controlling interests. Disturbances in the thermostatic control of the kidneys may result in profound alterations in urine formation ranging from complete anuria to intensive polyuria, with the production of anywhere from 0 to 20,000 cc. of urine a day. In the former, death in uremia results owing to the retention of toxic waste products whereas in the latter case, the patient runs a constant race between the water fountain and the washroom. The maintenance of normal kidney function is truly an amazing phenomenon of nature.

The Herculean task of filtering 500 gallons of blood each day is divided among approximately 2,500,000 excretory units, or nephrons. Each nephron consists of a glomerulus and a tubule. A tubule is divided into three anatomically and functionally distinct portions, namely the proximal, intermediate and distal tubules.

Cushny's classical theory of urine formation states that the formation of urine begins with the separation in the glomeruli of an ultrafiltrate identical in composition with the plasma except for the absence of plasma proteins and lipids to which the glomerular capillaries are presumably impermeable.

Cushny rejected the concept of tubular excretion because he was unwilling to accept such excretion on the basis of the vitalism doctrine, *i.e.* a vital activity on the part of the tubular cells. It was subsequently shown that the aglomerular kidneys of fish excrete magnesium, sulfates, chlorides, potassium, ammonia, creatinine and so forth, but never glucose. Thus the ability of the tubules actively to excrete waste products became established.

Concept of Clearance. Since fish tubules cannot *excrete* glucose, other carbohydrate derivatives were tested which could not be *reabsorbed* by the tubules. This led to the discovery of inulin as such a substance. Inulin is a starch-like polysaccharide composed of 32 hexose molecules (mostly fructose) with a molecular weight of 5200. It was found to be completely filterable by the glomerulus, physiologically inert and was rapidly and quantitatively excreted in the urine. Thus, if inulin is injected intravenously, it passes

through the glomeruli in the same concentration per unit volume as it is present in the plasma. It then passes down the tubules, being neither reabsorbed nor further excreted. Water is reabsorbed in the tubules and therefore the concentration of inulin rises. Thus, if one half of the water in the plasma ultrafiltrate is reabsorbed, the inulin concentration would be doubled. It is obvious that the ratio of the glomerular ultrafiltrate concentration of inulin (equivalent to the blood plasma concentration) to the urine concentration is an indication of the degree of water reabsorption.

$$\left\{\frac{U}{P}\right\} \quad \frac{\text{Urine conc. of inulin (mg./cc.)}}{\text{Plasma conc. of inulin (mg./cc.)}}$$

equals the degree of water reabsorption.

If the urine concentration (U) of inulin in mg./cc. is multiplied by the volume of urine (V) formed per minute, one has the amount of inulin excreted per minute. The concentration of inulin in the blood plasma (P) is the same as that in the glomerular filtrate since inulin is *completely filterable*. If one divides the amount of inulin excreted per minute in the urine (UV) by the blood plasma concentration of inulin (P), one arrives at the number of cc. of plasma which supply the urine with inulin each minute.

$$\left\{\frac{UV}{P}\right\} \quad \frac{\text{Urinary inulin in mg./min.}}{\text{Plasma inulin in mg./cc.}}$$

equals the cc. of plasma freed of inulin per minute.

The volume of blood plasma freed or *cleared* of inulin is identical with the volume of glomerular filtrate formed, the latter being merely an ultrafiltrate of the former and both containing the same concentration of inulin. Inasmuch as it is impossible directly to measure the volume of glomerular filtrate formed per minute, the volume of blood plasma cleared of inulin is used as a measure of the glomerular filtration rate. In man, an average of 131 cc. of blood plasma is filtered through the glomeruli each minute.

Urea Clearance. The rate of inulin clearance is unaffected by the urine volume per se, *i.e.* the amount of urine water reabsorbed by the kidneys. However, urea passively diffuses back across the tubules into the peritubular capillaries and is affected by the amount of urine water reabsorbed. The greater the water reabsorption, the greater is the urea reabsorption and the less is the actual urea excretion. In other words, the less the urine volume excreted, the lower will be the urea clearance because the numerator in the UV/P ratio is diminished. Thus, although urea is completely filterable at the glomerulus, the tubular reabsorption diminishes the normal urea clearance value from a potential 131 cc./min. (as with inulin) to approximately 70 cc./min. With urine flows of under 2 cc./min., owing to increased passive reabsorption, the urea clearance values fall even farther and are considered unreliable.

Diodrast Clearance. Diodrast and other iodized organic compounds are used to visualize the kidney for x-ray purposes. It was found that if the clearance values for diodrast or p-aminohippuric acid (PAH) were determined in a manner similar to that used for inulin, approximately 700 cc. of blood plasma was cleared per minute. Inasmuch as a figure of 131 cc./min. represents the rate of glomerular filtration, it follows that with a clearance value greater than the inulin clearance, PAH or diodrast must be excreted by the tubules in addition to being filtered through the glomeruli.

The determination of the extent to which the kidneys completely clear or excrete a given substance which comes to them in the renal blood supply can be made by direct comparison of the substance in the renal artery and the renal vein (extraction ratio). For diodrast and PAH these comparisons indicate that the kidneys extract between 74 and 87 per cent of these substances from the arterial blood. When allowance is made for the blood that passes elsewhere than through the glomeruli and tubules, the observed extraction ratio of from 74 to 87 per cent is probably closer to 100 per cent. Furthermore, since diodrast and PAH are bound to some extent to plasma proteins and therefore not filterable in this state, a further correction is added which increases the accuracy of the extraction ratio.

It appears that each cc. of renal arterial blood is practically completely cleared of injected diodrast or PAH as it flows through the kidney. If each cc. of plasma contains 1 milligram of PAH and if 700 milligrams of PAH is found in the urine *each minute*, it follows that 700 cc. of plasma must have flowed through the kidney *each minute*. From the hematocrit determination, the relative proportion of plasma in whole blood can be determined. Hence by correcting the renal plasma flow value (diodrast or PAH clearance) by the hematocrit reading for the plasma fraction, the whole blood volume flowing through the kidneys can be computed:

$$\frac{\text{PAH clearance (renal plasma flow/min.)}}{\text{Hematocrit (plasma fraction)}}$$

equals the effective whole blood flow.

In man the plasma PAH clearance = 700 cc./min., which is equivalent to 1200 cc. of whole blood. Thus if the cardiac output is approximately 5000 cc./min., the renal blood flow as given by the PAH clearance is about one fourth of the total cardiac output.

In severe renal damage or profound anoxia, not all of the renal blood supply may pass through the glomeruli and tubules; furthermore, damaged tubules may fail to excrete PAH. In these extreme conditions, the extraction ratio (fraction of arterial PAH excreted) may fall below 74 to 87 per cent. However, the residual nephrons may be expected to clear such blood as is presented to them. Thus, the PAH clearance will still be a measure of the *effective renal blood* flow to active tubular tissue.

Filtration Fraction. Having determined the inulin clearance (filtration rate) and PAH clearance (renal plasma flow), the per cent of the total renal plasma flow that filters through the glomeruli can be simply calculated as follows:

$$\frac{\text{Filtration rate (inulin clearance)}}{\text{Renal plasma flow (PAH clearance)}}$$

equals the filtration fraction.

The filtration fraction depends upon the following factors: (a) systemic blood pressure, (b) state of constriction or dilatation of the glomerular arterioles, (c) permeability of the glomerular capillaries, (d) the intrarenal or capsular pressure and (e) the duration of contact of the blood with the glomerular capillaries.

Tm Determinations. Two other determinations which can be used to test tubular function are the glucose-Tm and the PAH-Tm. In both the principle is to saturate the tubu-

lar mechanisms (Tm) by the intravenous injection of large amounts of glucose or PAH. The glucose-Tm measures the *maximal reabsorptive capacity* of the tubules and is determined by the number of nephrons which are producing a glomerular filtrate and also capable of reabsorbing glucose from this filtrate. PAH-Tm measures the number of excretory tubules whether glomerular or aglomerular. Thus, it measures the total quantity of *tubular excretory tissue* or mass in the kidneys. Since according to existing evidence only the proximal tubule excretes PAH, the tubular excretory mass is inferred to be physiologically active proximal tubular tissue.

Penicillin Clearance. The concept of clearance by the kidney of substances presented to it by the renal blood supply can be applied to various drugs that are used therapeutically. For example, the reason for frequent dosages in the use of penicillin is the rapid rate at which the kidneys clear this substance from the blood stream. In fact, the overall clearance of penicillin at all plasma levels studied appears to be equivalent to renal plasma flow as measured by diodrast or PAH. This means that some 1200 cc. of blood per minute is cleared of penicillin. For this reason it is extremely difficult to maintain bacteriostatically effective levels of penicillin in the blood stream. Approximately 20 per cent of the blood or plasma penicillin is filtered through the glomeruli, whereas 80 per cent is excreted by the tubules.

Recent work on the use of drugs to inhibit the excretion of penicillin substantiates the tenet that tubular excretion is not simply a matter of passive diffusion but involves expenditure of metabolic work. It has been shown that large doses of PAH or diodrast will block the tubular excretion of penicillin. It is assumed that these substances use the same tubular transport mechanism. Thus, if this mechanism is "saturated" by high blood levels of PAH, adequate blood concentrations of penicillin can be maintained for longer periods of time (PAH is believed competitively to inhibit the excretion of penicillin).

Recently a new drug, Caronamide, which is *not excreted* by the tubules, was found to block the tubular excretion of penicillin. Thus, Caronamide may act on the same transport mechanism as does PAH, but via another route. A working hypothesis is that the tubular transport mechanism is an enzymatic process utilizing penicillin as its substrate. It is further assumed that Caronamide (used in much smaller doses than PAH) competes with penicillin for the substrate rôle and thereby prevents the excretion of penicillin. This concept of competitive inhibition in enzyme systems has been nicely demonstrated in other biological phenomena. The application of the clearance concept has been useful in furthering experimental investigation in this connection.

The clearance methods of quantitatively measuring alterations in renal hemodynamics and renal function have been applied in numerous conditions of renal disease, such as glomerulonephritis, hypertension, lower nephron nephrosis, toxemias of pregnancy, shock and congestive heart failures. They offer great promise as research tools in the study of renal pathophysiology.—Jules H. Last, M.D.

FOOD SERVICE

CONDUCTED BY MARY P. HUDDLESON

Sound Consultation *Leads to Better Service*

FELISA J. BRACKEN
Home Economist
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Baltimore

NOW that the importance of nutrition and the advantage of having the food service controlled and supervised by a dietitian are recognized, there are not enough dietitians to meet the demand. Frequently, small institutions cannot afford and do not have the volume of work to warrant the full time employment of a qualified dietitian. When this problem exists a dietitian's services may be shared by several institutions if she is used as a consultant. However, if consultation service is to be worth while and effective it must include a greater scope of work than the periodic survey of menus and meal service.

Some Improvement Effected

For years physicians, board members or superintendents have called upon dietitians with whom they were acquainted to approve menus served in the small institutions under their supervision. Sometimes this led to improvement in the food service but not infrequently it was "paper work" which was only partially carried into operation.

One summer I visited a children's institution where they were serving for dinner shredded chicken and noodles, shredded boiled cabbage and boiled potatoes, white bread and milk and vanilla cornstarch pudding. The cabbage had been boiled until it was a pale tan. It was quite watery, as were the chicken and noodles. Can you picture this meal—colorless and "sloppy"? It certainly was far from appetizing, in addition to being starchy. It could have been quite different with a few changes. However, the people in charge were well satisfied with the meals they were serving these children. I don't know how the children felt—many were obviously hungry, some "dawdled" and a few refused to eat. One or two cried during the entire meal.

As I was being shown through the kitchen my guide pointed with pride to a framed copy of a set of menus for one week dated four months previously and signed by a prominent dietitian. She said: "See, our menus are approved by a dietitian!" I couldn't find anything on these menus which faintly resembled the meal I had seen that day.

As I knew the dietitian quite well I told her of my experience the next time I saw her and she was astonished. She said that early in the spring a member of the board of this children's institution had come to her with a set of menus all made out and asked for her approval. She had revised them and attempted to explain to the gentleman that there was need for continuous menu planning and food service supervision but he had no time for further discussion—all he wanted was one week's set of menus marked "approved."

Of course, there are institutions doing a good job of feeding the people in their care in which the staff has never heard of a dietitian or the work done by one. I visited one such institution at the request of the governing board. After a thorough study, which included among other things an analysis of the quantity of food consumed over a given period of time, I could confirm the fact that the women in the organization who had made this their life work were feeding the children and young adults in their care amounts of food which should ensure maximum nutrition, in the light of present knowledge, and were also making mealtime a pleasant, happy time.

My report was very reassuring to these women. They had hoped they were doing a good job. They often wondered if the children got enough milk, fruit and vegetables. Now they knew this was being accomplished and they also knew how to check on their work. Although these women were doing a good job, they plied me with questions every time I visited. Where could they get new recipes, new menu combinations, what could they do about girls who came to the institution overweight and needed to reduce? The physician had told them what the latter should eat but how could they make the diet attractive and arrange it so that these girls would really want to follow the physician's instructions and not be tempted to "break" their diets?

Must Recognize Problems

People in charge of small institutions must recognize that there are problems in relation to food service before they can use a dietary consultation effectively. Those who have struggled with food service problems for years must wonder that there could be directors who think they have no problems. We have found that people in charge of small institutions frequently do not recognize their problems in relation to food service. They say: "We have no food problems; we do it this way. It is the only thing we can do." Perhaps they do not have sufficient knowledge of the situation to know that they could improve it with not too much difficulty.

After recognizing that a problem exists, they must conscientiously want to do something about it and provide the means for carrying out any change before a dietary consultation can be effective. Providing the means for carrying out changes does not necessarily mean more money (frequently a dietitian can show an institution how to save money) but it does mean establishing continued supervision and authority.

At the beginning of the war some members of the Maryland Dietetic Association decided to offer a dietary consultation service to child care institutions as their contribution to the war effort. Notification of this service was sent to a long list of such institutions. Only a few requests for con-

sultation were received the first year. These were chiefly for help with rationing problems. Sometimes this would lead into the discussion of nutrition and food service. Sometimes it stopped when rationing tangles were straightened out. What happened frequently depended on the skill and available time of the dietitian.

Some of the institutions requested a continued service and new requests were received the next year. The dietitians began to find they did not have enough time to devote to these consultations. They had agreed to give their "free" time, but everyone knows what happened to "free time" in dietary departments during the war. Soon dietitians had little or no time off. In the year preceding the close of the war there were many more requests than could be handled.

So Much Needed Doing

The service was discontinued at the end of the war inasmuch as it had been set up for this limited period only. Looking back over the work accomplished, the various chairmen of the committee felt somewhat discouraged because there was so much that needed doing and they had been able to accomplish so little. However, from their experience they were able to draw some significant facts. There must be recognition of the problem, there must be continued service and there must be someone in each institution who closely supervises the food service, has the authority needed to get enough of the proper food and sees that it is served appetizingly and well. It is this person with whom the dietitian consultant should work closely.

The dietary consultation service should be paid for, the dietitians who worked with it agreed, because it has been found that administrators are more likely to carry out suggestions for which they have had to pay. The dietitian giving the service should be able to devote enough time to do a thorough and constructive piece of work. A full time dietitian might be employed to give dietary consultation service to a group of institutions without dietitians. Some state health and welfare departments have done this.

The consulting dietitian must be an experienced person who is familiar with quantity food service administration, as well as nutrition education methods. She also needs a special kind of skill in working with people over whom she does not have direct authority. As one member of the committee put it: "A dietitian accustomed to administering her own department finds she needs a different technic in making suggestions that will be carried out by another."

The American Dietetic Association became interested in the problem of consultation services to institutions without dietitians and for the last two years has made this one of its national committee projects. In working on this committee I have corresponded with dietitians and nutritionists in various parts of the nation who were offering this type of service or who were interested in starting a consultation service in their communities. Only a few local dietetic associations have done much of this work as a group activity but quite a few nutritionists with state health departments have done consultation work for public institutions along with their many other duties.

We found in Maryland that often the institutions wanted definite help with quantity buying, menu planning, recipes, food preparation and simple methods of food cost accounting, subjects with which the administrative dietitian is most familiar. On a national basis the most frequent requests seem to be for help with menu planning and quantity recipes and for informative leaflets and pamphlets. Our experience in Maryland has shown that we may actually need to go much farther than this, if there is to be marked improvement in food service.

What can the dietitian offer the small institution through consultation? An analysis of a week's consumption of food, as well as a criticism of the menus, is a much better indication of the adequacy of the meals than is approval of menus alone. The menus may look satisfactory on paper but the quantities served may not be adequate. Good menus do not mean good meals unless the food is prepared and served properly. The best recipes available are useless if the cook cannot read or does not like to use recipes. Sound consultation procedures easily lead to better methods of procuring foods and better methods of storage and preparation. In the hands of a capable consultant discussions may lead to something more constructive in relation to better food service than the mere handing out of menus and recipes.

The superintendent of a children's institution asked a dietitian to tell him what amount should be spent per person daily for food in order to obtain an adequate diet. He wanted to use this figure in going to his board of directors for more money, but he did not want to go any farther with a discussion of how to improve the food served in this institution. More money for food does not always mean a better diet or better food service.

The methods of buying, handling and serving and use of leftovers vitally affect costs. One large hospital in Baltimore has had a reputation over a period of years for serving good food, yet the food costs per person are relatively low. Sometimes an institution with what appears to be an adequate appropriation of money for food may have difficulty in obtaining adequate food within its allowance because items other than food, such as cleaning supplies, are charged to food costs.

Can Change Buying Methods

Frequently, small institutions can purchase more and better food by changing buying methods. We have found people in small institutions who were buying food on a retail basis because they were unfamiliar with wholesale buying and afraid of spending large amounts of money at one time. A dietitian can easily show how more food can be purchased for the same amount of money on a wholesale basis. She might go even a step farther and show how small public institutions, such as welfare camps and children's homes, can obtain more food for the same amount of money by using the services of the purchasing agent of a large city hospital or other large institution. She can show how to plan for food needs over a long period of time in ordering staple supplies. An inventory analysis may be helpful. She should be able to give information concerning simple methods of food control and cost accounting. She may need to help an institution get in touch with wholesale dealers who can take care of its needs and service in purchasing both food and equipment.

A dietitian offering consultation service may talk with boards of directors, superintendents or staff mem-

bers. There may be staff conferences of food service personnel. Institutes have been held in some states for directors and assistant directors of small convalescent homes. Educational exhibits and discussion groups may be part of the program. An institution may need help in regulating size of portions and in serving food attractively.

Improvement in food preparation and service means work with employes. This may lead to job analyses, routing of work and rearranging of work schedules, demonstrations of food preparation, educational films and short courses of instruction. The consultant may set up outlines of routine diets for kitchen staffs to follow; she may interpret special diets to kitchen staffs; she may suggest diet manuals or aid in preparation of a diet manual for a specific institution.

Looked Like a Prison

The service of attractive appetizing meals may also involve the arrangement and decoration of the rooms in which food is served. At a summer camp for children a lovely old gray stone barn had been converted into a dining room. The natural stone formed the walls. Quite a bit of money had been spent on the building but the woodwork, window frames and tables were all painted gray. Visitors invariably commented that "it looks like a prison." Fortunately the tables were repainted yearly, so a bright colored paint, such as orange, red or green, was suggested for the next year.

A study of plate waste may indicate points of attack in improving food service. It may also indicate the need for nutrition education among patients and staff.

Nutrition education can take the form of pamphlets for distribution in waiting and recreation rooms where patients help themselves from pamphlet racks. Posters can be placed in cafeterias, dining rooms and clinic waiting rooms. Films, filmstrips and other visual aids can be used in connection with planned programs for better nutrition. Nutrition instruction is especially important in tuberculosis institutions and maternity homes. If all patients cannot be interviewed, those who have diet problems and those who are to be discharged at least may be advised by a dietitian.

One state health department has employed a dietitian consultant who has instituted a patient and staff nutrition education program in all state tuberculosis institutions. There have been programs of films and talks in all institutions and she now plans to compile a small leaflet on the importance of nutrition in relation to tuberculosis to be given to each patient who enters the institution. After a trial period of volunteer consultation service, the department of welfare in another state employed a full time dietitian for consultation service and dietary supervision in all state welfare institutions.

Special types of institutions, such as outpatient clinics, nursery schools and day care centers, may utilize the services of a dietitian consultant in a way quite different from that of the hospital or institution in which the patient is provided with all meals.

One dietitian reported selling her services on an hourly basis for diet instruction of patients and the planning of diets for outpatients. Upon a doctor's request she would also visit a patient's home.

Another clinic consultant conferred with social workers and planned the activities of the nutrition clinic. Day care and nursery school programs may use a dietary consultant in work with directors and staff, with employes who prepare the food served and with parents of the children who are enrolled. During the war a nutrition consultant prepared menus for day care centers and menus for the parents to use to complete the day's meals served at home.

Pamphlets, periodicals, menus and recipes are often quite useful and helpful, but they should not be depended upon to do the job alone. Dietitians and nutritionists interested in the American Dietetic Association project on methods used in consultation service sent in many samples of effective materials. Among these were seasonal menus for institutions and a monthly leaflet, "Your Patient's Food," for the small hospital. Subjects discussed in the leaflet were: the postpartum diet, the liquid diet, the soft diet, menu planning, sources of quantity recipes and some diets for such special conditions as hypertension and obesity.

The consultation must be something in which the institution and the consultant both participate. The committee in Maryland has summarized the institution's part in the following manner:

1. To work out a plan with the consultant for regularity of visits and to arrange sufficient free time for those responsible for the food service so that they can participate in conferences with the consultant.
2. To plan, in advance of visits, insofar as possible, what problems are to be discussed. (The consultant needs to be entirely familiar with the situation in order to be helpful and the employes need to feel free to ask the help of the consultant.)
3. To furnish information concerning such problems as the types of patients cared for and the size of the group.
4. To furnish the consultant with the necessary material for an analysis of the food served, a week's menus and the list of foods used that week.
5. To arrange matters from time to time so that the consultant may observe meal preparation and service and taste the food.
6. To acquaint the consultant with the physical setup of rooms and other facilities in the institution concerned with the storing of food, its planning, preparation and serving. (It may be helpful to have a rough sketch of the setup.)
7. To designate someone in the institution who will take primary responsibility for working with the consultant and making practical use of the conferences. This might mean that such a person would plan the menus and furnish sample menus for the consultant to review, keep weekly food consumption records and submit them for occasional analysis. She would also consider with the consultant whether the recommendations made were helpful and could be carried out.

Written Reports of Each Visit

The dietitian should give the institution written reports of her study and recommendations after each visit in order that the staff may have something definite to refer to. These reports should be filed at the institution for future reference. The use made of the reports depends upon the administrator of the institution. In the interest of the nutritional well being of both staff and patients it is hoped that the reports will be kept readily available in a truly "active" file.

Recipes for *Conservation*

TO CONFORM with the National Food Conservation Program, the following popular tested recipes have been carefully selected. They are nutritious, flavorful and delectable and will meet with satisfaction from patients and personnel.

Escalloped Chicken and Macaroni

Yield: 50 Portions

1 pound macaroni, raw
3 quarts water, boiling
2 tablespoons salt
6 pounds 8 ounces chicken, cooked
14 ounces celery, raw
12 ounces pimientos
5 tablespoons onion juice
1½ gallons chicken gravy
1½ quarts coffee cream
Bread crumbs, buttered (for topping)
Salt and pepper to taste

Cook macaroni in boiling salted water until just tender. Drain and rinse in cold water. Chop the chicken in ½ inch pieces. Chop celery and pimientos in ¼ inch pieces. Grate the onion for the juice. Prepare chicken gravy so that it is of medium consistency. Add the heated cream, stirring constantly until well blended. Add the onion juice. Combine the macaroni, chicken, gravy, raw celery and pimientos, at the same time being careful not to break up chicken pieces or mash the macaroni. Season with salt and pepper to taste.

Place a cup of mixture in a preheated casserole. Sprinkle 1 teaspoon buttered coarse bread crumbs in the center of the dish. Bake in a 350° F. oven for from eight to ten minutes, until the mixture is thoroughly heated. Run the casseroles under the broiler to brown the crumbs.

Chicken Loaf

Yield: 3 Loaves, 15 Slices Each
45 Portions

15 to 17 pounds fowl, purchased weight or
4 pounds fowl, cooked, meat removed from bones
1¼ quarts chicken stock
2 cups top milk or cream
1 cup chicken fat or fortified margarine
1 cup flour
Salt and pepper to taste
3 cups celery, chopped very fine
12 eggs, slightly beaten
2 quarts cracker crumbs
3 tablespoons lemon juice

Remove cooked meat from bones; cut it into medium sized pieces. Heat the chicken stock and milk together. Melt the fat; stir in the flour; add the hot liquid and cook until thickened, stirring frequently with wire whip. Season to taste. Combine celery, eggs, crumbs and lemon juice with the chicken and gravy.

Put mixture into well greased loaf tins, using 4 pounds for each pan; pack well. Set these in pans of hot water and bake in moderate oven (350° F.) for about one hour. Test for doneness by inserting a knife blade into the center of the loaf; it will come out clean when loaf is done. Serve with mushroom sauce, rich chicken gravy or cream sauce with peas; the amount required is 4 quarts.

Escalloped Tuna Fish and Potato Chips

Yield: 48 Portions

1 cup onions, finely chopped
½ cup parsley, finely chopped
1 gallon medium white sauce
4 pounds potato chips, crushed
8 cans tuna fish (7 oz. cans)

Add onion and parsley to white sauce. Mix well. Grease three steam table pans (9½ by 12 by 2½ inches). Line each with crushed potato chips. Cover with a layer of tuna fish, white sauce and potato chips. Repeat, ending with potato chips. Bake in moderate oven (350° F.) for forty-five minutes.

Codfish Loaf

Yield: 50 Portions

6 pounds salt codfish
1½ quarts rolled oats (quick or regular, uncooked)
1½ quarts peas or green beans, cooked
1½ cups pimientos
9 eggs, beaten
2 quarts milk
1½ tablespoons salt
¾ teaspoon pepper
2 tablespoons prepared mustard

Soak codfish in cold water overnight. Drain, cover with water and cook until tender. Flake the cooked fish. Combine all ingredients with flaked codfish. Pour into greased baking dishes (six loaf pans, 4½ by 8½ inches), sprinkle with buttered crumbs and bake in a moderate oven (350° F.) forty-five minutes. Slice and serve with a cream sauce or tartare sauce.

Braised Oxtail Joints

Yield: 54 Portions

30 pounds oxtail joints
11 ounces flour
1 pound 8 ounces bacon fat or beef drippings
6 quarts beef stock
6 tablespoons salt
1 teaspoon pepper
1⅛ cups celery leaves
⅔ cup parsley
1 teaspoon mace
1 tablespoon peppercorns
1 pound onions, ground
4 pounds carrots, cut in strips

Wash oxtail joints. Melt bacon fat or drippings in roasting pan; add oxtail joints; sprinkle with flour; place in oven, turning meat frequently until evenly browned. Then add stock, salt, pepper, celery leaves, mace, onion and parsley and cook two to three hours till tender. The peppercorns may be tied in a bag and removed before serving. Cook the carrot strips in separate container and use to garnish the servings.

Vegetable and Meat Casserole

Yield: 40 Portions

1 cup chopped onion
½ cup shortening
2 quarts cooked ground meat (3 pounds)
⅓ cup salt
1 teaspoon pepper
2 teaspoons chili powder
2 quarts cooked potatoes, sliced or cubed
2 quarts string beans, cooked
2 quarts corn, cooked
2½ dozen medium tomatoes, sliced
3 tablespoons sugar
1 cup grated cheese
½ cup chopped parsley

Cook onion in the shortening until almost tender. Add meat and half of the salt; then the pepper and chili powder. Stir until well blended and until meat is partially cooked.

Grease three steam table pans (12 by 9½ by 2½ inches). Divide meat into three equal parts and place in pans. Place layer of potatoes over the meat; add a layer of string beans and a layer of corn. Sprinkle each layer with salt. Top with layer of tomatoes. Drained canned tomatoes may be used, if desired. Sprinkle top with remaining salt and sugar. Add cheese and parsley. Bake in moderate oven (350° F.) about twenty-five minutes.

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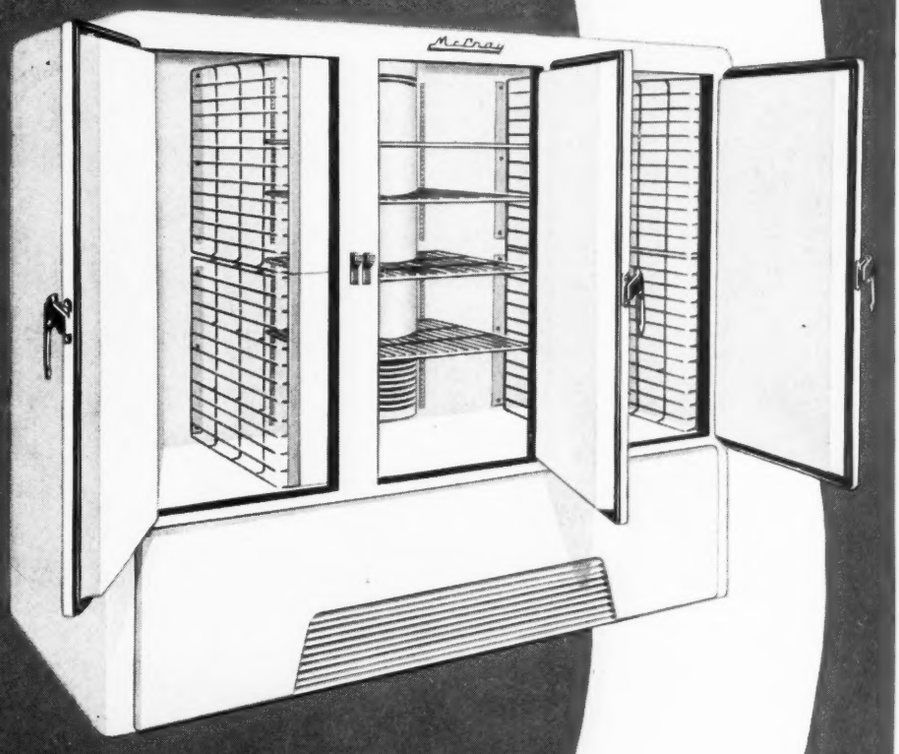

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McCray
KOLDFLO

Menus for January 1948

Lois E. Christensen
Concord Hospital
Concord, N. H.

1
Orange Juice
Hot Biscuits
•
Cranberry Juice
Celery Hearts, Olives
Roast Turkey, Giblet Gravy
Mashed Potatoes
Green Lima Beans
Grapefruit and Cherry Salad
Clover Leaf Rolls
Ice Cream
•
Consommé With Croutons
Sandwich Plate
Sliced Cling Peaches
Frosted Fruit Cake

2
Orange Halves
Soft Cooked Eggs
•
Broiled Halibut
Parsleyed Potatoes
Asparagus Tips
Sweet Relishes
Apricot Cobbler
•
Spanish Omelet
Green Salad
Vanilla Wafers
Frozen Raspberries

3
Mixed Fruit Cup
French Toast, Bacon
•
Meat Patties
Spanish Rice
Brussels Sprouts
Tossed Salad
Prune Whip With Custard Sauce
•
Cream of Mushroom Soup
Vegetable Salad Bowl
Hot Biscuits
Applesauce, Fruit Cake

4
Tomato Juice
Poached Eggs, Toast
•
Crown Roast of Lamb With Mint Sauce
Whipped Potatoes
Peas and Carrots
Radish Roses
Jelly Roll
•
Grilled Bacon in Toasted Cheese Rolls
Pineapple and Date Salad
Glazed Pears, Molasses Cookies

5
Kadota Figs
Raisin Toast, Plum Jam
•
Virginia Baked Ham
Candied Sweet Potatoes
Fresh Spinach
Mustard Pickles
Strawberry Bavarian
•
Scotch Broth
Creamed Asparagus in Toast Baskets
Stuffed Tomato Salad
Maple Junket, Chocolate Gems

6
Blended Juice
Shirred Eggs, Date Muffins
•
Chicken Pie With Biscuit Topping
Baked Hubbard Squash
Sliced Tomato Salad
Ice Cream Sundae
•
Corn Chowder, Crackers
Sweet Gherkins
Jellied Waldorf Salad
Coconut Layer Cake

7
Pineapple Juice
Hot Biscuits, Honey
•
Stuffed Beef Rolls
German Baked Potatoes
Green Beans
Celery
Cranberry, Tapioca Whip
•
Vegetable Juice
Baked Macaroni and Cheese
Hearts of Lettuce, Thousand Island Dressing
Apricot and Pineapple Salad
Gingerbread

8
Prune Juice
Pancakes and Maple Sirup
•
New England Boiled Dinner: Corned Beef, Boiled Potatoes, Beets, Carrots, Turnip, Cabbage
Chocolate Chip Ice Cream
•
Sweet Potato Casserole
Fresh Fruit Salad
Coffee Gelatin With Whipped Cream
Orange Cake

9
Stewed Apricots
Soft Cooked Eggs
•
Baked Haddock Fillets, Tartare Sauce
Buttered Potatoes
Harvard Beets
Endive With French Dressing
Lemon Meringue Pie
•
Shrimp Wiggle on Whole Wheat Rusks
Prune and Grapefruit Salad
Pumpkin Custard, Cheese Straws

10
Orange and Pineapple Juice
Broiled Bacon, Corn Bread
•
Meat Loaf With Mushroom Sauce
Potato Rosettes
Mashed Turnip
Celery Curls
Cream Puffs
•
Chicken à la King on Hot Biscuits
Julienne Vegetable Salad, Marjoram and Rosemary Dressing
Rhubarb Strudel

11
Grapefruit Juice
Creamed Eggs, Toast
•
Broiled Tenderloins
Delmonico Potatoes
Baked Stuffed Tomatoes
Sweet Pickled Cucumbers
Banana-Graham Fluff
•
American Chop Suey
Endive and Pear Halves With Sweet French Dressing
Angel Food With Maple Nut Ice Cream

12
Baked Apple
Scones, Marmalade
•
Veal Birds
Mashed Potatoes
Buttered Carrots
Olives
Tutti-Frutti Layer Cake
•
Red Flannel Hash With Mustard Dressing
Sunset Salad
Hot Rolls
Fruit Cup, Brownies

13
Pineapple Juice
Creamed Eggs
•
Broiled Swordfish With Lemon Wedges
Baked Potatoes
Broccoli With Hollandaise Sauce
Pepper Relish
Peach Sherbet, Vanilla Cookies
•
Cream of Spinach Soup
Tomatoes Stuffed With Crabmeat Salad
Toasted English Muffins
Cherry Cobbler

14
Grapefruit Half
Coffee Cake, Jelly
•
Smothered Steak
O'Brien Potatoes
Corn Niblets
Vegetable Aspic
Raspberry Shortcake
•
Escalloped Potatoes With Ground Ham
Apple Fritters
Celery Curls
Cream Puffs With Fruit Sauce

15
Bananas
Buckwheat Cakes, Sirup
•
Lamb Chops
Franconia Potatoes
Wax Beans
Minted Fruit Salad
Caramel Cream Pudding
•
Hot Mixed Vegetable Plate: Broccoli, Beets, Baked Potato, Squash
Pecan Buns
Curly Endive With Roquefort Dressing
Creamy Rice Pudding

16
Stewed Prunes
Fried Eggs, Toast
•
Broiled Mackerel With Lemon Wedges
Baked Potatoes
Rosebud Beets
Boston Cream Cake
•
Fish Chowder, Saltines
Cabbage and Pepper Ring
Queen Anne Cherry Salad
Frosted Marble Cake

17
Apricot Juice
Cinnamon Buns, Jam
•
Curry of Veal With Brown Rice
Sautéed Parsnips
Sliced Tomato Salad
Chocolate Tapioca With Whipped Cream
•
Stuffed Peppers
Deviled Egg Salad
Hermits
Sliced Oranges and Coconut

18
Tomato Juice
Poached Eggs on Rusks
•
Roast Pork With Applesauce
Boiled Potato Balls, Gravy
Broiled Eggplant
Curly Endive, French Dressing
Minted Fruit Cup
•
Escalloped Corn and Celery
Sausage Patties
Bow Knot Rolls
Asparagus Tip Salad
Baked Bananas With Lemon Sauce

19
Sliced Oranges
Canadian Bacon, Muffins
•
Meat Pie
Baked Potatoes in Half Shell
Mashed Turnip
Chef's Salad
Lime Whip With Lemon Sauce
•
Cream of Celery Soup
Grilled Club Sandwich
Carrot and Raisin Salad
White Layer Cake With Fruit Filling

20
Applesauce
Cheese Omelet, Jelly
•
Roast Turkey With Dressing
Boiled Potatoes, Gravy
Buttered Cauliflower
Cranberry Sauce
Glorified Rice
•
Welsh Rabbit on Rusks
Orange Cup Salad
Tapioca Cream
Butterscotch Crunches

21
Boysenberry Nectar
Muffins, Pear Jam
•
Baked Sausages
Mashed Potatoes
Julienne Carrots
Celery Hearts
Cornflake Crisp With Whipped Cream
•
Italian Spaghetti
Club Rolls
Garden Salad
Apple Dumpling With Heavy Cream

22
Grapefruit Half
Coffee Ring, Jelly
•
Ham and Mushroom Shortcake
Delmonico Potatoes
Wax Beans
Mustard Pickles, Celery
Sultana Rolls
•
Chef's Soup
Pigs in Blankets
Stuffed Apricot Salad
Strawberry Ice Cream on Sponge Cake

23
Fresh Orange Juice
Eggs à la Bird's Nest
•
Escalloped Clams
Baked Sweet Potatoes
Sour Burr Gherkins
Buttered Broccoli
Steamed Chocolate Pudding, Floradora Sauce
•
Cream of Asparagus Soup
Tuna Salad
Cornsticks
Tokay Grapes With Date Nut Bars

24
Pear Nectar
Shirred Eggs, Muffins
•
Liver Paste With Onion Rings
Whipped Potatoes
Carrots Glazed With Mint
Lettuce Wedges, Thousand Island Dressing
Banana Cream Pie
•
Eggs à la King in Patty Shells
Hawaiian Salad
Purple Prune Plums
Iced Cup Cakes

25
Stewed Prunes
Scrambled Eggs, Toast
•
Broiled Chopped Steak, Mushroom Gravy
Parsleyed Potatoes
Steamed Cauliflower
Grated Carrot and Raisin Salad
Coconut Cream Pie
•
Cheese Soufflé
Pear and Pimiento Salad
Butterhorn Rolls
Lemon Meringue Pudding
Lady Fingers

26
Boysenberry Nectar
Cinnamon Toast
•
Spareribs and Sauerkraut
Mashed Potatoes
Beets Julienne
Watercress
Maplenut Ice Cream
Ginger Gems
•
Creamed Chipped Beef
Baked Potatoes
Lettuce Salad With Chive Sauce
Fruit Cocktail
Fig Bars

27
Grapefruit Sections
Omelet, Toast
•
Baked Stuffed Haddock
Braised Potato Balls
Green Peas, Pearl Onions
Celery and Olive Salad
Fresh Raspberry Sherbet
Vanilla Wafers
•
Pepperpot Soup
Toasted Chicken Salad Roll
Sweet Gherkins
Pineapple Tarts With Whipped Cream

28
Orange Half
Soft Eggs, Pop Overs
•
Shepherd's Pie With Mashed Potato Topping
Mixed Vegetables
Pineapple and Cream Cheese Salad
Spanish Cream
•
Oyster Stew, Crackers
Sour Pickles
Sliced Tomato Salad
Pecan Pie

29
Fresh Orange Juice
Waffles and Sausage
•
Tomato Juice
Fricassee of Lamb on Steamed Rice
Asparagus
Fruit Gelatin With Whipped Cream
•
Chinese Chow Mein Noodles, Soy Sauce
Perfection Salad
Frosted Chocolate Brownies

30
Prune Juice
Poached Eggs on Toast
•
Broiled Finnan Haddie With Butter Gravy
Baked Potatoes
Spinach Timbals
Pickled Baby Beets
Apple Pie and Cheese
•
Vegetable Chowder
Mixed Fruit Salad
Cloverleaf Rolls
Gingerbread With Whipped Cream

31
Grapefruit Sections, Griddle Cakes With Molasses Sirup • Turkey Croquettes, Parsley Sauce, Riced Potatoes, Baked Acorn Squash, Tossed Salad, Chocolate Marshmallow Roll • Salmon Loaf, Butter and Egg Gravy, Baked Potatoes, Stuffed Celery, Orange Bavarian, Oatmeal Cookies

Ready-to-eat or cooked cereals are offered on all breakfast menus.

TO MINIMIZE THE NUTRITIONAL SETBACK IN SURGERY

Early correction of the unavoidable nutritional setback which follows in the wake of most operative procedures is considered advisable in the interest of more rapid return of the patient's strength and vigor. Furthermore, when early ambulation is permitted, caloric and nutrient intake must be adequate in order to prevent undue fatigue and to guard against defeating the very purpose of this practice. In such instances, a highly nutritious dietary supplement is advantageously employed.

Digested with remarkable ease, the delicious food drink made by mixing Ovaltine with milk can be given virtually as early as fluids are tolerated. This dietary supplement provides generous amounts of the very nutrients needed during the early postoperative period and, in addition, supplies readily available caloric food energy. Its delicious taste is universally acceptable and it is regarded as a treat by the patient when given as an afternoon snack or with other between-meal feedings. Note the well-rounded nutritional composition from the table.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

Three servings daily of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk,* provide:

CALORIES	669	VITAMIN A	3000 I.U.
PROTEIN	32.1 Gm.	VITAMIN B_1	1.16 mg.
FAT	31.5 Gm.	RIBOFLAVIN	2.00 mg.
CARBOHYDRATE	64.8 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U
IRON	12.0 mg.	COPPER	0.50 mg.

*Based on average reported values for milk.

PLANT OPERATION & MAINTENANCE

THE FUNCTIONAL BASIS OF HOSPITAL PLANNING

Plumbing Section

Continuing a Study by the
Division of Hospital Facilities
United States Public Health Service

OUTSIDE CONNECTIONS

PRELIMINARY: In selecting the hospital site, special consideration should be given to the water supply and sewage disposal. A site near a sewer of ample capacity and a satisfactory water supply should be given preference even if it is more expensive. When a sewage disposal system is necessary the state health agency should be consulted as to the requirements, type and design before the site is acquired to ensure a satisfactory location of sufficient size for the plant.

SEWERS: When a sewer is available, its elevation and capacity should be determined before the site is selected. If the site permits, the building should be set at an elevation which will permit gravity drainage to the sewer without overloading. Should it not be possible to drain the basement fixtures by gravity, two systems of drains should be used, one from the basement to the sewage ejectors and one from the upper floors direct to the street sewers.

Install in Duplicate

Because of the high initial cost and operation cost of sewage treatment plants, connection to an existing sewer system is usually more economical even though lift pumps or long connections are required. If lifts are needed, they should be installed in duplicate to assure uninterrupted service and, if occasional power shutdowns are likely, reliable emergency standby power should be provided for one of the lifts.

Each lift should have sufficient capacity to discharge the peak sewage load. The lifts should be float controlled and arranged so that if one fails or is overloaded the second will automatically go into operation. For capacities greater than 50 g.p.m. either pumps or air ejectors may be used. For capacities less than 50 g.p.m. air ejectors are more reliable. The collection well and lift station should be located outside the main building whenever practical and in all cases should be well ventilated.

The location and construction should be such as to prevent local odor nuisances and to protect against insects and rodents. In providing for the discharge of sewage into an existing system, it should be borne in mind that sewage from a hospital is more likely to contain infectious material than is the normal domestic sewage of the community. If a relatively large hospital discharges sewage into the sewer system of a relatively small community, special treatment of the community sewage may be required.

Where no community sewer system is available, adequate treatment of the sewage from the hospital is necessary. The objective of sewage treatment should be to prevent contamination and possible infection of a source of water supply, either surface or underground; to prevent possible spread of disease by rodents and insects; to prevent a nuisance condition, and to prevent destruction of aquatic life.

Hospital sewage often differs from average domestic sewages in that it contains a much greater proportion of laundry wastes. Interference with the biological processes usually employed in domestic sewage treatment is more likely. A competent sanitary engineer should be employed for the design of the treatment plant, and the design should comply with the regulations or policies of the state health agency.

Generally, effective settling and disinfection should be considered the minimum treatment of hospital sewage when it is discharged into a surface water course regardless of the dilution available. Additional treatment will be required when location and available dilution demand.

Ordinary Methods Applicable

The quantity of sewage from even a small hospital is so large that disposal by subsurface irrigation is not practical except under very favorable soil conditions. Ordinary biological processes of sewage treatment will usually be applicable, although when the water supply is heavily mineralized, interference with biological processes is a possibility. In such cases, consideration should be given to separation of wastes containing organic matter from inorganic wastes, such as water softener discharges, backwash water and boiler blow-off water. The latter contain no pathogenic organisms and are not putrescible, so final disposal is usually not a serious problem.

In locating the disposal plant, odors must be taken into account. If the plant is located close to the hospital or other built-up areas, all units should be housed and all openings should be well screened. Additional precautions against odor, such

as provision for chlorination, may be necessary.

Inasmuch as ordinary biological treatment of sewage does not destroy all bacteria, it must be assumed that the effluent from such plants will contain pathogens. Therefore, final chlorination of the effluent is indicated in all cases where the receiving stream is used as a source of water supply or for swimming or any other recreational use. Final chlorination may also be necessary where sewage is discharged into a water course which is dry during part of the year.

Should Not Cross Water Lines

Underground sewer lines from the building to the street sewer or to the disposal plant should not lie close to or cross over water lines. Insofar as is possible, the sewer should be lower than, and at least 10 feet horizontal distance from, any water line. If this proves impossible, heavy cast-iron pipe with calked lead joints should be used for the sewers. If it should be necessary to lay water and sewer pipes in the same trench, the sewer pipe should be laid in gravel fill at least 3 feet below the water pipe.

All kitchen fixtures should be connected through grease traps to the house sewer. Outside traps with one or more gasketed cast-iron covers are desirable as they permit access and eliminate odors from the kitchen. These traps can be of concrete or cast iron.

Storm Water Drainage: Roof, court, drive and areaway drains should generally be discharged into a storm water sewer, a natural drainage course or to dry wells wherever local conditions permit. Dry wells, if used, must be located at such a distance from the building that water will not seep into the basement.

Most local regulations prohibit the discharge of such drainage into a sanitary sewer system. Should it be necessary to use a sewage treatment plant for the hospital, such storm water drainage should not be admitted to the sanitary sewers. It would be uneconomical to construct a treatment plant for storm water load and this water would complicate operation of the sewage treatment plant.

When local regulations permit, storm water may be discharged into an existing combined storm and sanitary sewer. The capacity and loading of such a combined sewer should be carefully investigated and it should be determined that the additional storm water discharge from the hospital area will not result in overloading of the sewer to the extent that sewage will back into any part of the building.

Water Supply: The hospital water supply should be taken from a public system wherever one is available and can meet the maximum demand. The purity of the water supply should be determined by the state health or other recognized agency. If it is found unsuitable for drinking, provision should be made for a treatment plant. Two water services should be brought into the building from two street mains, if they are available, to provide an emergency service in case one main fails. Separate potable and nonpotable water supply systems are objectionable, as cross connections that would contaminate the drinking water are possible.

The minimum quantity and pressure of water available at the site should be checked accurately as they will affect the design of the water supply piping. Should they be inadequate, the structure of the building might be affected because a roof tank might be required. The mineral and chemical content of the water should be determined so that pipes which will resist corrosion can be selected.

Should the pressure in the street water main not be sufficient to supply the fixtures on the upper floors, a tank with duplicate fill pumps may be necessary. A simple balancing tank may serve when the water pressure is low for short periods. At times it is advisable to supply the laundry and first floor fixtures from the street main and pump the water for the upper floors. Where a public water supply system is not available, water wells should be considered in preference to the use of surface water which would require a treatment plant and constant supervision. In all such cases the state health agency should be consulted.

PLUMBING SYSTEMS

Plumbing Stacks: Space for plumbing stacks should be considered when preliminary plans are being prepared. Chases and shafts for stacks should be run to clear spandrel and floor beams. Steel beams should not be located under partitions on which there are plumbing fixtures and should be arranged so as not to interfere with drain lines in furred ceilings. Drain lines and offsets should not be located above kitchens, food preparation or storage rooms or ice tanks. Thick partitions and furrings will be required for wastes and soilstacks. In cold climates, water pipes should not be located in outside walls. Floor plans should be so arranged that plumbing fixtures will be placed one above the other to reduce the number of stacks.

Soil, Waste and Vents: The mechanical plans should show all soil, waste, drain, vents and plumbing connections. This can be done satisfactorily only by showing the connections to stacks in plan and by diagram. In determining sizes and methods of connecting branches and vents, the city or state codes, when they are complete and adequate, should be followed. Should no such local plumbing code cover special hospital equipment and connections, the requirements of the Plumbing Manual B.M.S. 66 of the National Bureau of Standards should be followed.

Prevent Back Flow

Soil and waste connections must be sized and pitched to drain freely and prevent back flow to other fixtures and to floor drains. Each fixture must be connected separately, with individual traps. Venting systems must be provided, so that no fixture can lose its protective seal by water forcing and siphoning, which would permit sewer gases to enter the hospital. Accessible cleanouts at points where pipes change direction are desirable to remove stoppages.

Bedpan washers must have vapor vents to relieve the pressure and remove vapors. Vapor vents from bedpan washers and sterilizers must not be cross connected with other vents but must be extended independently through the roof. Vapor vents from other sterilizers to the roof are recommended. Vapor eliminators, or cold water condensers, are available but the excessive quantity of water used and the additional manual control valve make them objectionable.

WATER PIPING: The sizes of all water pipes should be determined and shown on the plans and diagram. These sizes should be large enough to permit an ample flow of water to the probable maximum number of fixtures which may be used at one time. Water requirements can be determined from the data given in the Plumbing Manual B.M.S. 66 of the National Bureau of Standards, provided due allowance for corrosion and deposits is made. The velocity of water in pipes which are too small will generate noises and cause water hammer. The friction in small pipes after some years may be so great that an adequate water supply cannot reach the fixtures on the lower floors, while the upper floors are without water. In extreme cases water may be drained from the upper floors and cause back siphonage from upper floors to the lower fixtures.

Can Use Reducing Valves

The water pressure should be adequate to supply 15 pounds' pressure to the upper floors when the maximum number of fixtures that will be in operation at one time are supplied. If the pressure on lower floors is greater than is permissible for quiet operation (approximately 40 pounds), reducing valves should be employed. It is advisable to use two pressure reducing valves in parallel, one for the minimum demand and the second set to supply the maximum demand. Objectionable variations in water pressures may be caused by the maximum and minimum demands and long mains, but with pipes of proper size this will not be noticeable. In most cases the size of the street service will be determined by the requirements of the standpipe system.

WATER SOFTENERS: The use of hard water is disagreeable and requires excessive soap. Water softeners should be used when the water is objectionable or when the cost of the additional soap required for laundry is greater than the operating cost of a water softening plant. This will usually be the case if the hardness exceeds 4 grains per gallon. The local laundries can usually furnish reliable data on the treatment, if any, that will be advisable.

In some cases satisfactory results may be had by treating only the water supplied to the hot water heaters. The flush valves and other fixtures can be operated satisfactorily with the hard water. Zeolite is employed in softeners to remove the calcium from the water. The calcium which is deposited on the zeolite is removed by washing with salt water. As considerable space is required for salt, a storage room is necessary, as well as space for the tanks. Excessive corrosion may be caused by zeolite, in which case corrective treatment should be considered.

HOT WATER SYSTEM: It is advisable to use two combination hot water heaters and storage tanks with horizontal submerged copper "U" tube heaters. The tanks should be copper lined or fabricated with noncorrosive shells. Manholes for cleaning and openings for thermostatic controls are recommended.

One tank should normally be used for the laundry, dishwashers and pot sinks, with a water temperature of 180° F., and the other, with water at 150° F., for the hospital fixtures. Through the use of booster heaters for pot sinks and dishwashing equipment, the water for the kitchen may be taken from the 150° F. service. The tanks should be cross connected so that either can be used to supply all fixtures during cleaning or emergency repairs. This arrangement requires two systems of hot water piping, but the additional cost is not great because the mains to the laundry and kitchen are usually short.

For a general hospital, the minimum hot water requirements that may be expected are 8 gallons per bed per hour for the laundry and kitchen and 5 gallons per bed per hour for the hospital. The storage capacity should be not less than 80 per cent of the heater capacity. Tanks should be constructed to comply with the A.S.M.E. code for pressure vessels and should be connected with vacuum, pressure and temperature relief valves.

All hot water risers and the ends of mains that are not connected to risers should have circulating lines to maintain hot water at all fixtures. To avoid air traps, the circulating risers should be connected just below the branches to the highest fixtures supplied by the riser.

WATER CONNECTIONS: Water supply connections to lavatories, sinks, tanks and all fixtures and equipment should be made above the rim or highest water level to provide an air gap so that back siphonage cannot be established. Hose connections at sinks and bedpan cleansers should not be long enough to reach the water in the fixtures. For lavatories and sinks this is accomplished with gooseneck or high faucets.

Drinking fountains with paper cups are preferable to bubbler fountains from a health standpoint. If bubbler drinking fountains are used, they should be of the angular stream type with the outlet well above the rim fixture. The water supplies to dishwashers, stock kettles and such equipment should be connected above the overflow level.

Meters Permit Check

Recommendations for air gaps at water supplies and for back flow prevention are discussed in report B.M.S. 28 of the National Bureau of Standards. Water should not be cooled by direct contact with ice. Meters on the water main from the street and on the cold water connection to the water heater serving the laundry permit a satisfactory check to be made of the water consumption.

FIXTURES: Vitreous china or an approved material that will not stain is necessary for plumbing fixtures. If porcelain enameled fixtures are used, they should be of the acid resisting type. Vitreous china or stainless metal is preferable. Fixtures should be supported by wall brackets to eliminate legs or supports from the floor. Heavy fixtures should be supported on chair carriers, and light fixtures should be bolted through partitions to steel plates. Drain and water connections should be run to the partitions rather than to the floor to prevent dirt pockets and to eliminate openings through floors which might permit scrub water to drip to the ceiling below.

The heaviest line of brass faucets available should be used, with interchangeable parts and washers. Built-in stops at fixtures are desirable to permit replacing washers and making repairs. Dull chromium plated fittings at fixtures are recommended to eliminate polishing. For scrub-up sinks and lavatories for doctors and nurses, the faucets should be of the knee action type. Other lavatories and sinks should have faucets with the spade type of wrist action

Delaware Hospital, Wilmington, Delaware

Heated by 6-zone Webster Moderator System of Steam Heating. Completed in 1942. Unit No.1, center, occupied in 1940. Architects: Massena & duPont, Wilmington. Consulting Engineers: Jaros, Baum & Bolles, New York. General Contractor: Turner Construction Co., Philadelphia. Heating Contractor: Benjamin F. Shaw Co., Wilmington.

3 Trap Replacements in 7 Heating Seasons

When a hospital spends in the neighborhood of $30,000 annually for fuel oil, that's big business. It calls for a "controllable" steam heating system and careful heating plant operation to effect maximum economies.

The outstanding heating record of the new Delaware Hospital began with a Webster Moderator System designed by the well known New York engineering firm of Jaros, Baum and Bolles. It included installation by a competent heating contractor.

Continuity of operating experience is provided by Chief Engineer Carl A. Baehr, who has been with the new Delaware Hospital from the beginning. Let Mr. Baehr tell you about some of the heating economies.

"Out of 1,981 Webster Radiator Traps in use, only three have required new thermostatic interiors in seven years of service. The Webster Radiator Supply Valves have been completely satisfactory.

"We receive no more than six legitimate heating complaints a year, and correction is always promptly made. During fuel rationing we effected a number of operating economies. Stairway radiators were turned off. Radiators in the clinics, X-ray laboratory, solariums and business office were shut down at 4 p.m. and turned on at 8 a.m. This manageability is characteristic of modern steam heating systems.

"Sometimes an unusual amount of heat is required in a particular room for a limited time. Instead of turning the Variator to full heat with consequent overheating of other rooms, we remove the Webster Metering Orifice from the radiator supply valve in less than three minutes. Later it is replaced."

The Delaware Hospital was only partially completed at the time fuel rationing went into effect. It was estimated that the completed Hospital would require 620,000 gallons of fuel oil per year. Based on this estimate, the fuel rationing board allotted 500,000 gallons of oil per year for all purposes—heating, sterilizers, laundry, kitchen equipment. Fuel consumption records show that the Hospital did not require a supplementary ration at any time during fuel rationing. The Webster Moderator System saves fuel by keeping radiators comfortably warm. Instead of 212 degrees, the average surface temperature of radiators is 185 degrees, 150 degrees or even as low as 90 degrees, depending on the need for heat.

Let Webster experience help you in your heating system management problems. The service of long-time Webster Representatives and the performance record of proven Webster Heating Systems is a combination that means comfort and economy.

WARREN WEBSTER & CO., Camden, N. J.
Representatives in principal U. S. Cities : : Est. 1888
In Canada, Darling Brothers, Limited, Montreal

WEBSTER
MODERATOR
CONTROL
"Control-by-the-weather"

or with knee action. Gooseneck or high faucets should be used for patients' and nurses' lavatories and for lavatories and sinks at which basins and pitchers will be filled.

The lever type of foot operated flush valves is recommended for toilets. Toilets should be of the quiet-acting swirling siphon jet extended-lip type. Both the flush valve and stop should have silencers. Back flow preventers with nonreturn stops are required. Seats should be of the open-front composition type with stop hinges. Toilets for private rooms should have bedpan cleansers fitted with recessed shut-off valves, back flow preventers and hand controlled hose nozzles.

Sinks and special equipment should be located as shown by plans of the special departments. Lavatories should be of the wall hung type, set 31 inches high, with stops, gooseneck spouts and knee or elbow action control as described. Splash backs should be used on plastered walls. A single elbow operated handle to control both hot and cold water is preferred by some doctors.

Dental lavatories are desirable when washrooms are provided for ambulatory patients, and specifically in T.B. washrooms. If coolers are used, it is recommended that paper cups be supplied.

Hose connections that are used at sinks, necropsy tables and for washing bedpans should be of such length that the end of the nozzle cannot be submerged. Back siphoning valves of a type approved by the state health agency should be used on such hose connections. Hose connections for necropsy tables can be suspended from the ceiling to keep the end of the hose above the table.

Pantry and flower sinks on patients' floors should preferably be of stainless steel, although acid resisting enameled iron may be used. They should be not less than 60 inches long over all, with backs, aprons and two integral drainboards. They should be wall hung and provided with crumb strainers and swing spouts. Plaster sinks for orthopedic work should have splash backs, gooseneck spouts, wrist action control and enameled iron interceptors.

Janitors' sinks should be of acid resisting enameled iron, with backs. They should be set into the floor, the rim from 6 to 8 inches above the finished floor, so that the tile base can finish under the rim. Rim guards and braced bucket hook spouts should be provided. Receptors set in the floor may be used instead of sinks. All connections to kitchen and laundry fixtures should be included in the plumbing contract.

STERILIZERS: Inasmuch as proper sterilization is one of the basic requirements of a hospital, the subject deserves much study. Sterilization may be accomplished by boiling water, by steam under pressure and by heated dry air; of the three, sterilization by steam under pressure is quickest and most reliable. Electrical sterilizers can be used when steam is not available, but they are more expensive and do not heat as rapidly. Gas sterilizers are not recommended. Hot air sterilizing is required in laboratories and for certain surgical supplies.

The central supply department should be equipped to sterilize and furnish all instruments, appliances and dressings used in the care and

treatment of patients. Some hospitals prefer central sterilization of the utensils, such as bedpans, urinals and basins, which are usually sterilized in the utility rooms. If this is the established policy the bedpan washer and sink are used for routine cleansing and utensils are sterilized only when assigned to a new patient or when special conditions require. Sterilizers may then be omitted from the utility rooms.

The "clean" sections of these rooms may also be omitted if adequate treatment rooms are provided. If central sterilization is planned, flasks of water may be sterilized in the central autoclaves and distributed to the various departments. This procedure is considered preferable to the use of water sterilizers whose operation cannot be so carefully controlled.

Pressure sterilizers or autoclaves usually operate from a central steam supply of 40 pounds' pressure. These are replacing many of the boiling sterilizers, as the higher temperatures that can be maintained reduce the time required to assure proper sterilization. Sterilization, of course, is dependent upon maintaining the temperature for a predetermined period, preferably in the presence of moisture. For this reason, it is imperative that the sterilizer be free of air and that recording instruments and thermometers be provided. For proper sterilization, a sustained steam pressure of from 15 to 17 pounds is required. Pressure sterilizers should be insulated and recessed when conditions permit to avoid overheating of work spaces.

Bedpan washers are, in effect, disinfectors rather than sterilizers. Wall-mounted types allow cleaning of the surrounding floor more readily than does the pedestal type, but the latter is more accessible for maintenance. Flushing is by cold water jets, followed by live steam under pressure. Every precaution must be observed to prevent the possibility of back siphonage and cross contamination. The state health agency should review proposed installations. Separate vapor vents are required and traps should have cleanouts.

Valves: Each plumbing fixture and each piece of equipment should have stop valves to permit repairs or replacement of washers without disrupting service to other fixtures. Each group of fixtures on a floor, each riser, each branch main and each main supply line should be valved. Each valve should have a numbered brass tag permanently attached. A diagram and valve schedule, showing the location and purpose of each valve in all systems of piping, should be prepared and framed under glass. Water operated aspirators should not be used in operating rooms.

Flush Valves: In some cases flush valves have been found objectionable in hospitals on account of noise and the danger from back siphonage. Quiet operating valves with quiet regulating stops, when used with a quiet acting bowl of the swirling type, can be used satisfactorily. By using nonreturn stops and back siphonage valves with the flush valves the danger of back siphonage can be minimized, but only tested and approved devices should be used. To avoid the transmission of noise caused by the flow of water, plumbing fixtures should not be located on partitions between patients' rooms.

(*Continued on Page* 118.)

SPECIAL SYSTEMS

Fire Standpipe System: The National Board of Fire Underwriters and the local fire department should be consulted to determine the requirements for the standpipe system. Hose and Siamese connections must have threads to fit those of the local fire department. The flush type of fire hose cabinets with glass fronts is advisable. Chemical extinguishers set in recessed cabinets should also be provided, approximately 100 feet apart, at accessible points on all floors. When standpipes are installed, these extinguishers can be mounted in the hose rack cabinets. For storerooms, kitchens, shops, laboratories and all areas that are not under constant supervision, automatic sprinklers are desirable.

Gas Piping: Gas piping for ranges and similar equipment should be approved by the A.G.A. and installed and tested as required by the gas company and local regulations. Piping of anesthetic gases to operating rooms from a central point is not recommended. Should a central oxygen supply be used, special manifolds should be connected with copper tubing in accordance with the requirements of the company that will furnish the oxygen. Oxygen tanks should be in a locked closet or room near the delivery entrance. Outlet valves in the patients' rooms should be set in recessed boxes with hinged doors.

Vacuum System: In small hospitals, portable explosion-proof suction machines will serve the needs of the operating room and necropsy room. Larger hospitals may have suction piping from a vacuum machine in the basement, connected to hose outlets in the laboratory, morgue, delivery rooms and operating rooms. Special automatic vacuum machines with tanks are available for such services, but care must be exercised to soundproof the rooms in which they are located.

GENERAL

Pipe: Cast-iron pipe is recommended for soils, wastes, vents, leaders, sewers and underground lines, as its life for such service is greater than that of other pipe. Bell-and-spigot cast-iron pipe is not desirable for connections smaller than 2 inches. When screwed cast-iron pipe is not available, extra heavy galvanized steel or iron pipe can be used for the smaller sizes. Special acid resisting cast-metal pipe should be used for laboratories. Copper pipe with soldered fittings should be used for water lines and oxygen connections except in areas where the water may attack the copper.

Concealed pipe should be of a material which will have a life equal to that of the building. Copper tubing lighter than type "L" should not be used, and in all cases high temperature solder should be employed. Standard weight steel or iron pipe can be used for fire lines, with fittings specified by the National Board of Fire Underwriters. Standard weight steel or iron pipe is used for gas.

Fittings for the drainage system should be of the sanitary type, with brass cleanout plugs at all changes in direction and at ends of lines. For cleanouts under floors and in other concealed locations, the lines can be brought up to the floor or wall and terminated with special plates. Hinged steel access doors with angle iron frames should be provided for all valves and cleanouts which can-

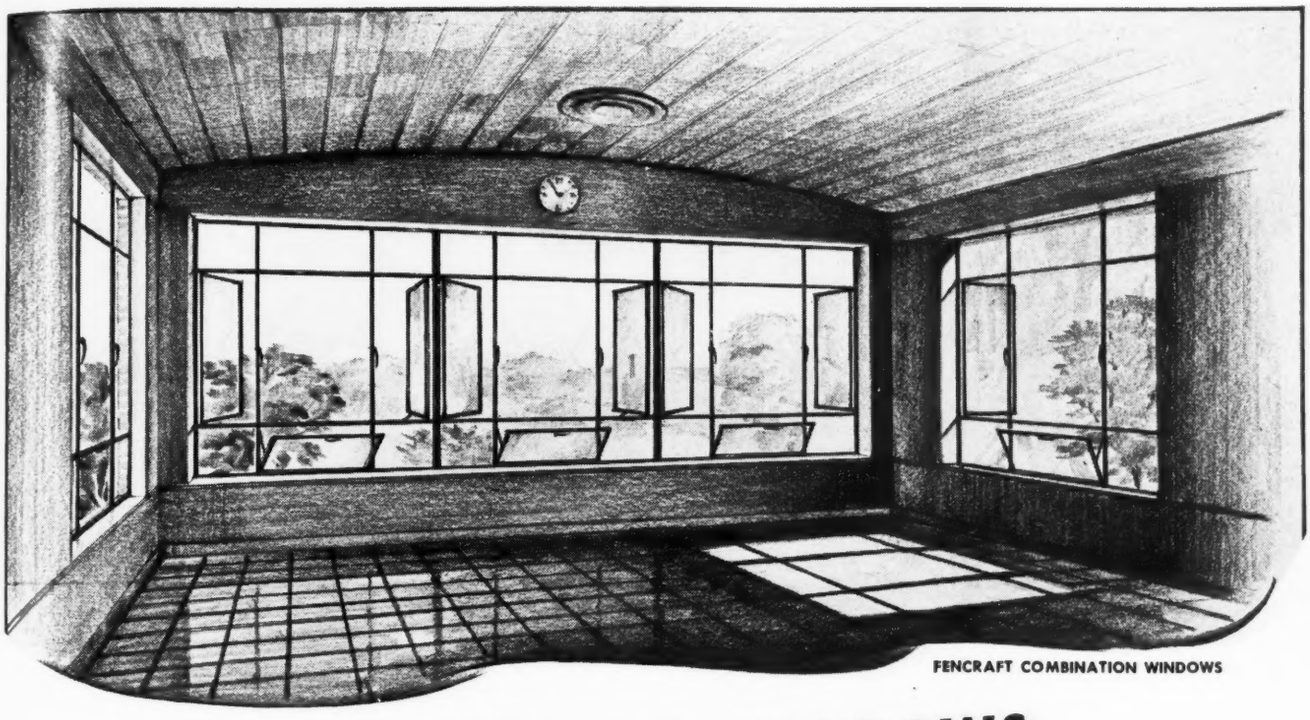
not be reached otherwise. Galvanized iron sleeves should be provided wherever pipes pass through floors or partitions. Where exposed pipes pass through floors, the sleeves should be of I.P.S. galvanized iron pipe with floor and ceiling plates screwed on.

INSULATION: Hot water pipes and hot water tanks should be well insulated to conserve heat and to avoid overheating the rooms above. Cold water pipes and offsets in leaders should be insulated to prevent dripping from condensation and to reduce the transmission of sound. Pipes in outside walls should be insulated to prevent freezing. Soil lines over or near patients' bedrooms should be wrapped with felt and paper or other sound insulation.

NOISE CONTROL: Many hospital noises are generated by the plumbing systems, but most of these can be eliminated by observing common preventive measures in locating and designing the piping systems. Water and drain pipes should be located away from patients' rooms whenever possible. Fixtures should not be placed against partitions between patients' rooms. Leaders and drain lines, if offset above patients' rooms, should be soundproofed.

High pressure water passing through faucets will cause squeaks which can be eliminated only by lowering the water pressure with reducing valves, though they may reduce by partially closing the shut-off valves. High water velocities, which cause water hammer and water noises, can be avoided by using pipes of ample size. Gooseneck faucets should be designed so drips will clear the drain opening, as a faucet drip in a patient's room may be as annoying to the patient as are pipe noises. Pumps, compressors and motors should be set on sound insulation to prevent the transfer of vibration to piping and building.

INSTRUCTIONS: While the piping and equipment are being installed, a manual for operation and maintenance of the mechanical plant should be prepared; it should contain manufacturers' literature on the equipment. Floor plans and diagrams showing all piping and valves should be filed. All valves should have brass tags and should be scheduled. Pipes should be marked with distinctive colors approved by the A.S.A. and A.S.M.E.



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Look at the possibilities for fresh-air control in these Fencraft Combination Windows. The hopper sill vent deflects air upward, provides protection from drafts; sheds rain or snow outside. The swing-vents reach out to scoop in the breezes when more ventilation is desired. Vents stay open in the selected positions.

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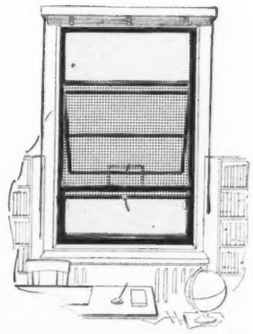
Safe outside washing—from inside. Easy to operate. Interchangeable inside screens, protected from outside dirt. "Homey" appearance makes them ideal for nurses' homes and staff houses.



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Open-out vent acts as weather-protecting canopy over opening. Open-in vent deflects air upward, sheds water outside. Movable air-conditioning unit may be easily attached.

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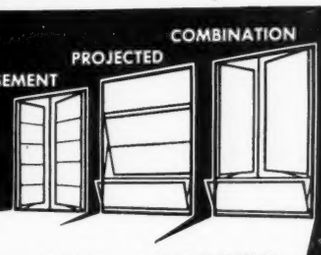

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HOUSEKEEPING

Conducted by Alta M. La Belle and Jane Barton

Skilled "Diagnosis" Solves Laundry Problems

FRANCES W. PENFIELD
Executive Housekeeper, Delaware Hospital, Wilmington, Del.

THE problem of furnishing adequate and properly washed linen is a major consideration in many hospitals. The comfort of the patient is influenced greatly by the condition of the linen used. It not only should be pleasing to the eye but should be washed with a formula that removes the alkali which so often is allowed to build up. Alkali causes the linen to become harsh and starchy in feeling and irritated knees, elbows and buttocks result.

Then again if the laundry equipment is not adequate, linen is often washed in a shorter space of time than is desirable and numerous complications result, such as too great a loss of whiteness and neglect of the important matter of proper rinsing.

Preserves Tensile Strength

Whiteness retention can be lower in the hospital laundry than it can be in a commercial laundry where whiteness is a selling point. With a good formula, the retention can easily be kept points lower for hospital work and in that way many pounds of tensile strength can be preserved.

The first step is to check the formula in use to see if changes are desirable. To do this a tensile strength test bundle should be procured from a laundry supply company and care and accuracy in following directions should be insisted upon.

The procedure is simple; it consists of washing a square of muslin 20 times with the regular wash load and then cutting off a quarter of the square. This is done four times in all which means that the square is finally cut into four equal pieces. The first will have been washed 20 times, the second, 40 times, the third, 60 and the fourth, 80 times. These pieces should be marked "first," "second," "third" and "fourth" and returned to the laundry's laboratory for analysis. Commercial laundries often show a preventable loss of from 12 to 14 pounds and many hospital laundries, as much as 10 ond," "third" and "fourth" and reduced to as low as 2 pounds without jeopardizing the cleanliness of the linen.

Precautionary technic for a hospital laundry is also a matter for careful consideration. A large Connecticut hospital was faced with the problem of worn out equipment in its isolation pavilion and the need either for replacement or for the work to be done outside. Few commercial laundries care for this type of work, which increased the problem. It was finally decided to authorize the hospital laundry manager to investigate laundries elsewhere and make recommendations.

After a number of institutions handling this type of work had been visited it was decided to wash the contaminated linen in the regular laundry at the hospital. This work was not to be opened until the rest of the washing for the day had been completed. The contaminated linen was to be received in bags tightly tied. Woolens were to be placed in bags marked as such and were to be handled separately from the linen. Laundry baskets marked for the isolation unit were used to transport the clean linen and were unpacked in a clean room for that purpose and returned on the same trip to the hospital. No counting or sorting of the soiled linen was done.

When all was ready, the bags were untied and emptied directly into the prepared wash wheels, and the bags were then thrown in and washed in the same load. These bags, when filled, had the tops turned back about a foot so that no contamination would reach the outside. If the bags were kept dry, the outside was considered uncontaminated. The regular formula was used in the washing procedure, but, after the bath, live steam was used for fifteen minutes with the thermometer never lower than 215°F. In twelve years no case of cross infection had developed and the heavy cost of new machinery had been avoided.

An intelligent survey of machinery needs is the next step and the importance of this cannot be overestimated. It is advisable to consult representatives from competitive laundry machinery companies whose services are available without cost. In this way expert advice can be had from those highly experienced in the laundry field. If this is done, there will be a need for a count of linen turned out by the laundry for one week's time so the amounts to be handled can be estimated, this work to be classified as starched, tumbled or flatwork.

A house census for the week, with the number of operations and deliveries, will also be needed. When the production needs are known, the representative will be able to estimate the proper amount and type of machinery necessary.

Sufficient Steam Pressure Needed

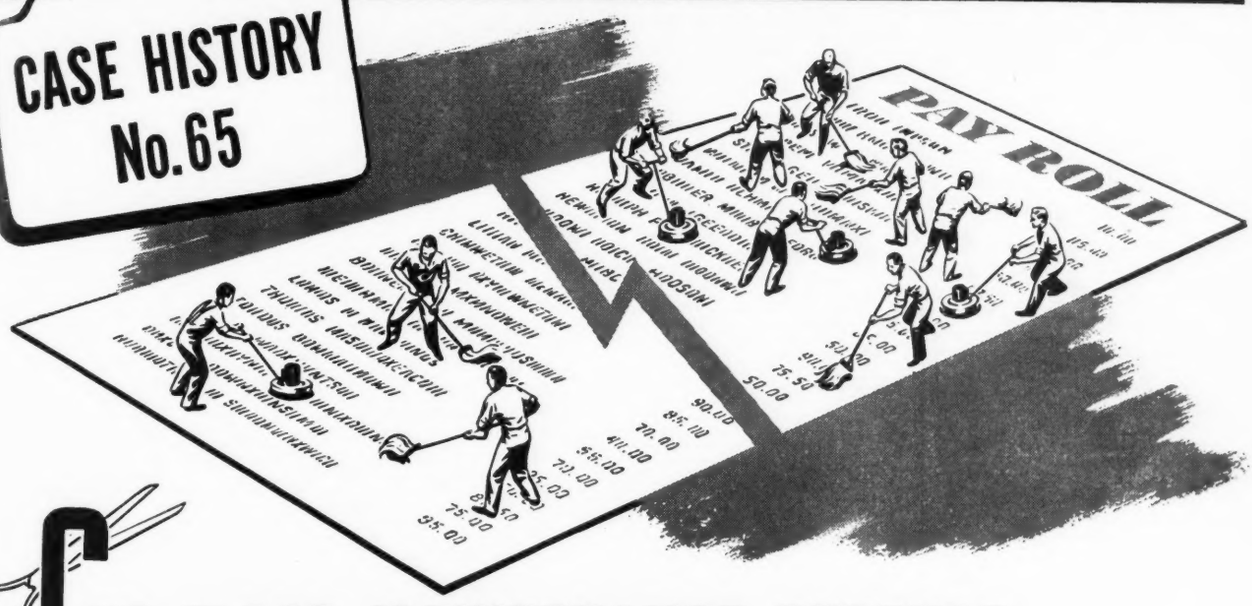
Another problem that is often encountered is the matter of having sufficient steam pressure, which is sometimes hard to keep up to the necessary level and without which great loss of efficiency from the flatwork ironer is evident. If live steam is to be used for sterilization of contaminated linen, it is essential that a sufficient amount be available. One hundred pounds of pressure is to be recommended but, if that is impossible, 90 pounds will suffice.

Adequate space for sorting of soiled linen before washing is also important as much time is lost in shaking out wet material.

If labor accounts for 85 per cent of the cost of operation, it can easily be seen that machinery of the newest and best type will rapidly pay for itself.

IN A SERIES OF SUCCESS STORIES WITH THE LEGGE SYSTEM OF NON-SLIP FLOOR MAINTENANCE

CASE HISTORY No. 65



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EIGHT MEN toiled all night...a total of 64 man-hours...to give a floor of this institution its weekly polishing.

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(3) Has slashed floor accidents up to 95% for hundreds of users. Leading casualty insurance companies recommend the lasting anti-slip protection of a Legge program to policyholders to overcome slip hazards. Legge materials are also approved by testing laboratories.

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NEWS DIGEST

Maryland-D. C. Group Stresses Cooperation Between Hospitals, Public Health Agencies

BALTIMORE. — Cooperation between public health facilities and Maryland hospitals was the major theme of the seventh annual conference of the Maryland-District of Columbia Hospital Association meeting held November 10 and 11 at the Lord Baltimore Hotel in Baltimore. The basis of such argument centered about the recent report of the State Hospital Survey Committee. Said Dr. Lowell J. Reed, vice president, Johns Hopkins University, "Associations such as the Maryland-District of Columbia group have a definite place in the unification of our hospital system. Hospitals have now become big business," he went on. "They employ about 1 per cent of the laboring force of this country—as many workers as such fields as coal mining, printing and publishing or the public utilities."

Carrying the subject still futher, Dr. John Whitridge Jr., obstetrical consultant of the State Department of Health, stated that the close cooperation of health officials and hospitals in several counties has benefited all concerned—the community, individuals, the hospitals and health department workers.

Emphasizing cooperation between the city health department and hospitals, Dr. Harry L. Chant, District Health Officer of the city's Eastern Health District, outlined the work and plans of the new medical care section of the city health department. "One of its major purposes," according to Dr. Chant, "is the elimination of the duplication of services and the centralization of facilities and records."

That there will be an expansion of premedical care plans was predicted by Dr. George Baehr, president, New York Academy of Medicine and professor of clinical medicine, Columbia University. Dr. Baehr proceeded to describe the part that hospitals would play in the future as medical centers. "They will be something better than mere boarding houses for sick people, as most of them are at present," he declared. "They will assume full responsibility as educational institutions for all the physicians of the community in which they are located."

There should be a 50 bed hospital within 30 miles of everyone, according to Graham L. Davis, president, American Hospital Association. Describing the work of the Kellogg Foundation in Michigan he said that rural hospitals are becoming health centers as well as places for treating the sick and injured. Under such a program he predicts that it is likely that within the next fifteen or twenty years tuberculosis will be as rare as typhoid.

In describing the survey that has been made of the state hospital's needs, J. Douglas Coleman Jr., executive director, Maryland Hospital Service, Inc., and secretary of the association's committee on medical care, explained that this had been used to set the priorities for construction under the federal hospital building program which has made $870,000 of federal funds available annually to the state. This money is to be supplemented by local funds.

James G. Caposella, superintendent, Emergency Hospital, Washington, D. C., succeeds Dr. Edwin L. Crosby, director of Johns Hopkins Hospital, as president. Brody J. Dayton, director, Peninsula General Hospital, Salisbury, is the president-elect for 1949. Other officers are: vice presidents, J. H. Nies, Takoma Park Sanatorium, Sister Veronica, Mercy Hospital and Sister Marie, Provident Hospital, Washington; secretary-treasurer, R. R. Griffith, West Baltimore General Hospital, and trustees, P. J. McMillin, Baltimore City Hospitals and Dr. Crosby.

Bradley, Hawley Resign From V.A. Posts; Gray Succeeds Bradley

WASHINGTON, D. C.—Maj. Gen. Carl R. Gray Jr. has been appointed Veterans Administrator to succeed Gen. Omar Bradley, President Truman announced November 21. General Bradley has been named army chief of staff, replacing General Eisenhower. General Gray, who was director general of military railway service in the European theater of operations during the war, has been serving since that time as vice president in charge of public relations for the Chicago and Northwestern Railway. Before the war, he was president of the Chicago, St. Paul, Minneapolis and Omaha Railway, a Northwestern subsidiary.

Announcement was also made of the resignation of Maj. Gen. Paul R. Hawley as chief medical administrator. The new Veterans Administrator will appoint Dr. Hawley's successor. It is considered probable that Dr. Paul B. Magnuson, noted orthopedic surgeon who is the head of the V.A.'s professional services, will be appointed.

26 State Plans on Way to Completion Under Hospital Survey Act

WASHINGTON, D. C.—Fifty-three preliminary hospital plans have already been received for tentative approval under Public Law 725, Surgeon General Parran announced last month. Sixteen state plans have been finally approved and 10 others are nearing completion. Dr. Vane Hoge, hospital facilities administrator, expects that all plans will be in by the end of this fiscal year. It is anticipated that actual construction will be under way on several projects by the end of the calendar year. The 26 state plans already completed, or nearing completion, will bring the total allotments of federal funds up to $48,000,000, it was announced.

The Hospital Survey and Construction Act authorizes federal grants up to a maximum of $3,000,000 to assist the states in surveying their needs for health facilities and drawing up long range plans to meet these needs. It also authorizes $75,000,000 yearly for five years to assist the states, their political subdivisions and voluntary nonprofit organizations in building hospitals and health centers. Each dollar of federal funds must be matched by two from state or local sources. Under this arrangement, a total of $1,125,000,000 may be spent for construction during the five year period.

Blain Joins Georgetown Staff

WASHINGTON, D. C.—Dr. Daniel Blain, nationally known psychiatrist, has been appointed to the Georgetown University School of Medicine faculty, it was announced here October 28. He will hold the chair of professor of psychiatry and director of the department of psychiatry. Dr. Blain served from 1942 to 1945 in the U. S. Public Health Service with the rank of lieutenant commander. He was later detailed to the Veterans Administration as assistant medical director, chief of the division of neuropsychiatry.

Iowa Joins Upper Midwest

IOWA CITY, IOWA.—Trustees of the Iowa Hospital Association voted unanimously in a meeting on November 8 to become a charter member in the Upper Midwest Hospital Conference, Gerhard Hartman, president, announced. The trustees elected Harold Wright, Methodist Hospital, Sioux City, Iowa, and Mr. Hartman to serve as trustee members on the board of the Upper Midwest conference.

Baruch Urges Compulsory Health Insurance for Low Income Groups

NEW YORK.—Government sponsored health insurance for low income groups offers the best solution to the problems of distribution in the medical care field in the opinion of Bernard M. Baruch, New York financier and economic adviser to several national administrations.

Mr. Baruch's views were presented in the principal address at a dinner, November 20, celebrating the progress of Associated Hospital Service, New York Blue Cross Plan and the United Medical Service, the affiliated medical prepayment plan. The dinner was sponsored by the Greater New York Hospital Association and state and county medical societies.

Before an audience of 600 New York physicians, hospital administrators and public health officials, Mr. Baruch charged that many members of the medical profession had been "fighting a rear guard action for too long," against the type of social insurance he recommended. Stating that his interest in the medical care problem resulted from the manpower survey he made for the late President Roosevelt early in the war period, Mr. Baruch stated, "I was shocked to learn that 4,000,000 men had been rejected as unfit to defend their country."

Mr. Baruch would not abolish voluntary prepayment plans. These have a definite place in the medical care picture, he stated, but he pointed out that many families cannot afford voluntary insurance. "What of the little fellows who cannot?" he asked. "I have asked that of everyone with whom I have discussed medical care. Nothing has been suggested so far which promises success other than some form of insurance covering these people by law and financed by the government at least in part—what some people would call compulsory health insurance."

Mr. Baruch commended the medical program of the Veterans Administration under the Bradley-Hawley administration as an example of government-doctor relationship. He proposed a federal health agency of cabinet rank to integrate all government health activities now distributed throughout several agencies and bureaus.

Other features of the medical care program outlined by Mr. Baruch included: greater emphasis on chronic diseases; mental hygiene and preventive medicine; better distributon of hospitals and physicians; more general practitioners; increased emphasis on group practice; medical research, rehabilitation and preventive care for children.

"Many doctors and many lay people have sought to paint the issue of government health insurance as a choice—all black or all white," Mr. Baruch declared. "I have found every aspect of medical care to be gray—the happy color sensible compromise wears.

"All law imposes compulsion. A form of compulsory health insurance for those who cannot pay for voluntary insurance can be devised and adequately safeguarded without involving what has been termed socialized medicine. The needs can be met as in other fields without the government taking over medicine—something I would fiercely oppose.

"That is why I urge doctors to get in and pitch—not stand by on the sidelines. You need fear politicians or bureaucrats only to the degree you fail yourselves," he told his professional audience. "You must take the leadership, or rather, yours is now the leadership—keep it."

Urges Single Unified Drive to Raise Funds for Chicago Area Hospitals

CHICAGO.—A single unified drive to raise funds for voluntary hospitals in the Chicago area was recommended last month by James A. Cunningham of the building fund campaign for St. Luke's Hospital. Mr. Cunningham said Chicago hospital groups should combine their efforts into a "greater Chicago hospital drive" aimed at raising $50,000,000 for the city's voluntary hospital needs.

Mr. Cunningham's suggestion was made in a speech officially opening the St. Luke's campaign for a $3,500,000 building fund. "Hospital fund raising campaigns totaling around $20,000,000 in objective are in progress in Chicago and its suburbs today," Mr. Cunningham said. "All these represent duplication of effort and expense.

"Some of them will succeed, some will fail but even if they are all successful the amount realized will be $30,000,000 short of the sum needed to build adequate hospital defenses for the city," he declared.

Mr. Cunningham said a recent survey showed Chicago and surrounding communities needed nearly 5000 additional hospital beds. He pointed out that hospitals such as St. Luke's which were best equipped to raise funds themselves would be the last to receive grants from the proposed joint hospital fund which he said should be administered on the basis of priority needs.

Practical Nurse Corps May Solve Nursing Shortage, Fishbein Says

CHICAGO.—Development of a practical nurse corps which will take over many nursing duties at the hospital bedside "may be the answer to the major portion of the nursing problem," according to Dr. Morris Fishbein of the American Medical Association. In an editorial published in *Hygeia,* an American Medical Association magazine, Dr. Fishbein discussed the extent of the nursing shortage and suggested that training programs for practical nurses probably offer the best solution.

A shorter working week, new hospital construction and wider use of hospital facilities were listed as contributing factors in the shortage. Dr. Fishbein expressed doubt that much could be accomplished through training male nurses.

"The point of view is well established," he said, "that nursing is primarily a woman's profession. Competition from men will hardly be a factor for a good many years."

Compensation Rates Raised in New York

NEW YORK.—A statewide increase in New York compensation rates paid to hospitals for patients covered under the New York law was announced effective November 1. Under the new agreement, bed, board, routine nursing, ordinary dressings and drugs are covered up to $8.60 a day for hospitals in the state. The previous rate was $7.50 for hospitals in the New York metropolitan areas and $7.19 a day for other parts of the state.

Under the new agreement, further adjustment in the rate can be made in the future as additonal data may warrant such action.

Cornell Employes Honored

NEW YORK.—Two hundred employes who have served New York-Cornell Medical Center for fifteen years or more were honored at a dinner given by the board. The honor group received silver pins for fifteen years of full time service and gold pins for twenty-five years or more. The event also marked the fifteenth anniversary of the opening of the Medical Center at its present location at 68th Street and the East River. Speakers included Dr. Joseph C. Hinsey, dean of the Cornell Medical College; William Harding Jackson, president, New York Hospital; Dr. Stanhope Bayne-Jones, president of the joint administrative board of the hospital and university, and Dr. George W. Wheeler.

Nebraska Hospital Association Elects Donald W. Duncan

OMAHA, NEB.—Donald W. Duncan, business manager of St. Elizabeth's Hospital, Lincoln, was named president-elect of the Nebraska Hospital Assembly at the annual meeting here November 14. Mr. Duncan is also secretary-treasurer of the assembly.

Reverend E. C. McDade, superintendent of Bryan Memorial Hospital, Lincoln, took over the presidency from Cecelia Meister of York General Hospital during the assembly. James Carr, office manager of the University of Nebraska Hospital, was elected to the assembly's board of trustees.

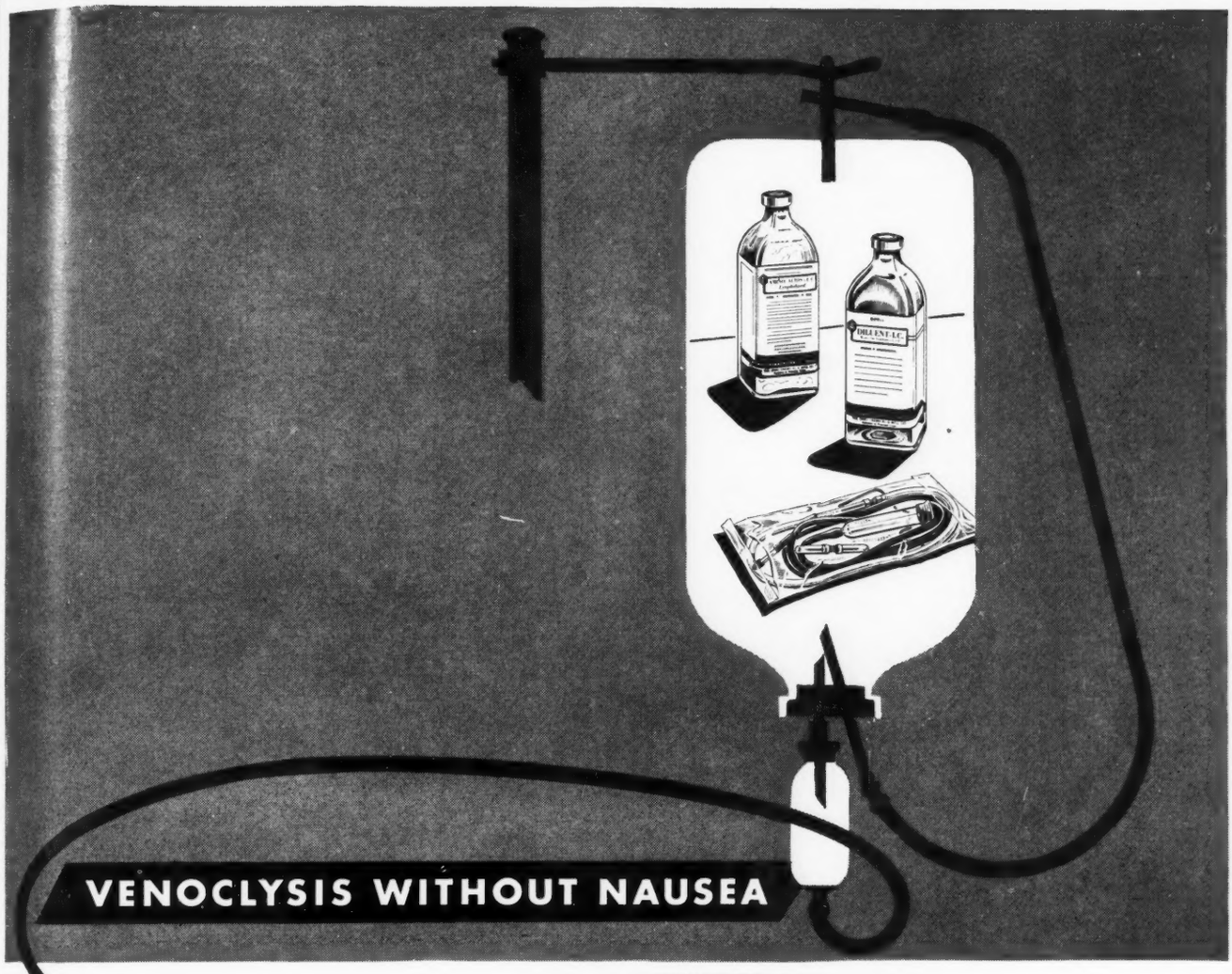
In a two day program attended by nearly 100 hospital administrators from throughout the state, the assembly discussed as major themes teamwork in hospital obligations, unrecognized problems in hospital administration, trustee relations and problems relating to medical staff organization. Among the speakers were Dr. Malcolm T. MacEachern who discussed teamwork within the hospital and addressed the annual assembly banquet on "The Hospital of the Future"; Graham L. Davis, president of the American Hospital Association, who described the regional hospital plan for Michigan; George Bugbee, A.H.A. director, who reported progress on the federal hospital program; Jon Jonkel, Chicago public relations consultant, and R. M. Cunningham Jr., managing editor of The MODERN HOSPITAL.

The hospital administrator who builds team spirit among his employes gets better results, Dr. MacEachern told the assembly. All staff members and employes should be encouraged to participate in planning hospital rules and policies, he said.

The assembly heard discussions of press relations by a representative of the *Omaha World Herald* and industrial relations by the superintendent of Swift and Company's Omaha plant.

To Survey Cholera Situation

WASHINGTON, D. C.—R. Adm. M. D. Willcutts, Medical Corps, U.S.N., and Capt. Leroy D. Fothergill, Medical Corps, U.S.N.R., left November 4 for an extended tour through Europe and the Near East to conduct a survey of the cholera situation in those areas. They will also evaluate results of the treatment following the navy's contribution of 60,000 pounds of badly needed vaccines and drugs. Both doctors are experts in the field of epidemiology. They will confer with the Naval Medical Research Institute No. 3 in Cairo, Egypt, which is assisting the Egyptian government in fighting cholera.



VENOCLYSIS WITHOUT NAUSEA

Rapid intravenous infusion of protein hydrolysates has been accompanied from time to time by such reactions as nausea and vomiting. Madden and his co-workers* found a definite relationship between these reactions and the level of glutamic acid in the administered preparation. More recently, Smyth and his co-workers** verified this finding in a study of 115 hospital patients.

It is noteworthy that in the preparation of AMINO ACIDS-I. C. *Lyophilized*, a 50% reduction of the glutamic acid content has been achieved. Therefore this *adjusted amino acid complex* is unlikely to provoke nausea and vomiting when given at physiologically optimal rates. Descriptive literature will gladly be sent.

*Madden, S. C., et al: Tolerance to Amino Acid Mixtures and Casein Digests Given Intravenously; Glutamic Acid Responsible for the Reactions, J. Exper. Med. 81:439 (May) 1945.

**Smyth, C. J. Lasichak, A. G. and Levey, S.: The Effect of the Rate of Administration of Amino Acid Preparations and Blood Amino Acid Nitrogen Level on the Production of Nausea and Vomiting, J. Lab. and Clin. Med. 32:889 (July) 1947.

FEATURES

- *rich in essential amino acids*
- *assayed microbiologically*
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Seek Funds to Solve Financial Difficulties of Four Hospitals

By EVA ADAMS CROSS

WASHINGTON, D. C.—Enabling legislation is being sought from the state of Maryland as a possible means of solving the financial problems of Suburban Hospital, Bethesda, according to Arthur B. Solon, the hospital's administrator, October 31. The institution faces a deficit of $60,000 by the end of the year. Of the aid measures contemplated, one would authorize the county to purchase the hospital from the federal government, the other would permit a grant up to $50,000 in financial relief.

In critical financial condition also are three other hospitals built in 1943 in nearby war-impacted communities with Lanham Act funds—Alexandria, Va., Arlington, Va., and Prince Georges at Cheverly, Md. Alexandria Hospital received a grant from F.W.A. under the Lanham Act and hence belongs to the community. But the others were constructed entirely under wartime Lanham Act funds and belong to the federal government.

It is known that the Federal Works Agency hopes to sell at reasonable prices to the local communities such hospitals as it built for them with federal funds. Prince Georges County has already practically completed arrangements to buy its hospital, hitherto leased from the government. It is, in addition, floating an $800,000 bond issue to pay for increased facilities.

Most of Suburban's deficit has been caused, according to the administrator, by the inadequate pay allowed by the county for indigent patients sent to the hospital by the County Welfare Board and Community Chest agencies. Actual cost to maintain a patient in the hospital is more than $13 per day. The county allows only $6. County patients make up about 20 per cent of the hospital's normal occupancy of from 75 to 80 per cent. The hospital is considering increases for private rooms and for two and four bed wards.

Arlington Hospital has run into the red to the tune of $48,443 also largely because of inadequate payments for charity patients. This institution receives only $5 per day for indigent cases from the Health Security Administration which dispenses Community Chest funds. Arlington County makes up a part of the difference between $5 and the actual cost of the county's H.S.A.'s patients. But Fairfax County which supplies some 60 per cent of the charity load does not. The hospital loses around $10 per day on each charity patient.

Arlington Hospital has increased its rates for the second time in three months for semiprivate beds. The increase runs from 50 cents to $1. Private room rates remain unchanged at $9 and $10 per day.

Alexandria Hospital, too, has encountered its chief loss from inadequate rates for charity patients. It has asked the city authorities for a daily rate of $8.81 for indigents, plus an outright grant of $30,000. The Alexandria City Council has agreed to $7 per day for charity patients but has denied any further increase. This rate of $7 per day, the hospital refuses to consider. Hospital officials will not resume negotiations with the council until a rate survey started a few months ago has been completed.

Appoint Medical Adviser

WASHINGTON, D. C.—Veterans Administration announced November 5 the appointment of Dr. William A. Hunt to the V.A. national advisory board on medical problems. Dr. Hunt is professor of clinical psychology at Northwestern University. The board, appointed in compliance with Public Law 293, 79th Congress, acts in an advisory capacity to Gen. Omar N. Bradley, Administrator of Veterans Affairs, and Dr. Paul R. Hawley, chief of V.A.'s Department of Medicine and Surgery.

Final Report of Research Board Urges $300,000,000 Fund

By EVA ADAMS CROSS

WASHINGTON, D. C.—National expenditures for medical research should reach $300,000,000 annually, the President's Scientic Research Board declared in its fifth and final report October 18. The expenditures for such research should be three times the present annual sum of $110,000,000. This expansion should be brought about as quickly as possible and it should come in large part from public funds.

Federal funds should supplement and not replace funds spent by industry and nonprofit organizations. The government should not adopt any policy with reference to medical research which will have the effect of discouraging or driving foundations, private philanthropy and private health organizations from the field. The stimulation of fundamental discoveries must be a keynote in the overall expansion of medical research.

There is a critical shortage of investigators in all categories of medical and allied research. The National Institute of Health junior and senior fellowship program should be expanded substantially within the next few years. Senior fellowships should be lengthened from one year to at least two years and an option should be provided for additional years in special cases.

It is more important than ever before that the federal government attract and hold a sufficient proportion of high quality medical research scientists, the report continued. They should be included in the policy making structure and given some responsibility and authority in budgeting and personnel processes. Salaries up to $15,000 a year, as provided for some 45 scientists in the National Military Establishment, should be authorized throughout the government.

An advisory committee of government and nongovernment research scientists should be established at once, the board urged. This medical research committee, at least at the outset, should function as a subcommittee of the interdepartment committee recommended in an earlier report. The committee should be wholly advisory and should concern itself with large scale, long range planning for a national medical research policy. There has been no national policy heretofore for medical research.

Texas Center Plans Children's Hospital

HOUSTON, TEX.—Plans for a 200 bed children's hospital and other allied units to be built on a 6 acre tract in the Texas medical center were laid before some 200 doctors at the annual Texas Pediatric Postgraduate Conference in Houston last month. Dr. John K. Glen, Houston pediatrist and member of the Texas Children's Foundation, outlined the complete children's center plan, which includes the hospital, a children's disease research unit, postgraduate pediatric school, special children's hospital for communicable diseases and a special surgical hospital for children.

The complete medical center plan was presented by Dr. E. W. Bertner, president of the Texas Medical Center. He described the general hospital, the tuberculosis hospital, cancer hospital, central outpatient clinic and other features that the medical center will have for medical education, care and research.

Army Consultants Meet

WASHINGTON, D. C.—More than 100 army medical consultants met here November 5 for the second annual convention of the Society of United States Medical Consultants of World War II. Cooperation was pledged between civilian and army doctors to give American soldiers the best medical care in the world.

Whitton Resigns as Administrator of Alexandria, Va., Hospital

Robert G. Whitton, administrator of the Alexandria Hospital since 1941, resigned November 22 following publication of a survey in which hospital accounting and administrative procedures were sharply criticized.

Mr. Whitton's resignation, which was accepted by the hospital board to become effective not later than April 1, 1948, was tendered "in the best interests of the hospital and the absolute need for it to operate successfully and with full community support," he said in a letter to the board.

This action culminated a week of discussion of hospital affairs touched off by the report of a survey made by Dr. Joseph R. Clemmons of New York to determine whether or not the Alexandria City Council should increase rates paid for care of indigent patients.

The report was made to the city council and released publicly November 15. Observers in the hospital field criticized the hospital board and its survey committee for making the survey findings public before the report was acted on by the board and without affording the administrator an opportunity to answer the criticisms it contained.

Recommending that the council pay $8.81 a day as requested by the hospital and that an additional grant of $20,000 a year be made by the city to the hospital, the survey nevertheless severely criticized the hospital's administration and particularly its accounting and cash handling procedures.

Mr. Whitton described the report as "acceptable" and added that "criticism of the administration is a little tough to take in view of the record of my achievements since March 1941. I am willing to stand on my record and accept the favorable evaluations of men and women working with me, and my associates in the hospital field."

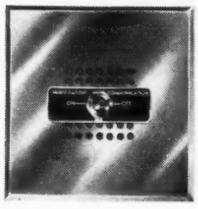
$4,000,000 Expansion Program

CHICAGO.—An expansion program totaling more than $4,000,000 for the Columbus Hospital here has been announced by Mother General Antoinette Della Casa of the Missionary Sisters of the Sacred Heart, the order which operates the hospital. The expansion program includes a new hospital building of 400 beds, bringing the total capacity of the hospital to 600 beds and a shrine honoring St. Frances Xavier Cabrini, founder of the Sacred Heart Sisterhood. Construction of the addition has already been undertaken, the announcement said, and it is expected that the hospital will be in operation early in 1949.

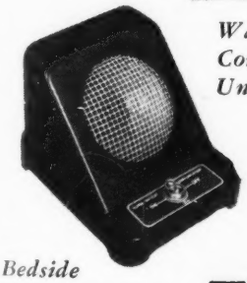
Nurse-to-Patient Communication

A NEW, IMPROVED IBM SERVICE TO HOSPITALS

Nurses' Call Button



Wall Communicating Unit



Bedside Communicating Unit

IBM

IBM's complete nurse-to-patient communication system brings new efficiency and convenience to the operation of any hospital.

When a patient registers a call by pressing the luminous Nurses' Call Button, the nurse establishes communication through the control panel on her desk. Nurse and patient then can carry on a two-way conversation—the nurse by means of a telephone attached to the control panel, and the patient by speaking into a bedside or wall type communicating unit.

Other IBM helps for hospitals are Nurses' Call Systems, Doctors' Paging Systems, and Doctors' Staff Registering Systems.

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Time Recorders and Electric Time Systems • Proof Machines Electric Punched Card Accounting Machines and Service Bureau Facilities • Electric Typewriters

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Johns Hopkins Opens Group Clinic in Outpatient Department

BALTIMORE.—Inauguration of a group clinic in the Johns Hopkins Hospital outpatient department, making possible a study of the medically indigent patient's diagnostic problems by specialists and medical students, has been announced by Dr. Edwin L. Crosby, hospital director. Dr. Crosby said the following advantages were foreseen for the clinic, which began operation with the current medical school year:

Better initial and after care for ambulatory patients in the outpatient department.

Immediate consultation by physician, surgeon and necessary specialists during the examination of patients presenting a multiple diagnostic problem, with resultant reduction in the amount of time spent and the number of visits made to the department.

An increase in the number of laboratory tests done routinely for each such patient.

Better teaching of the medical student in ambulatory care as the student participates in the examination of the patient with physician, surgeon and specialist.

The plan was formulated after a year long study by a joint committee of the hospital's departments of medicine and surgery. A similar plan was pioneered by the Presbyterian Hospital in New York in 1946, Dr. Crosby said.

The outpatient department of the Johns Hopkins Hospital sees more than 1000 patients each day, but of these an average of only 100 are what the hospital terms new patients—patients being seen for the first time or patients who have been seen previously but are now presenting another episode of illness.

The functioning of the new clinic was described as follows by Dr. Crosby:

The patient is interviewed and, if necessary, given a preliminary examination in the outpatient department admitting office. If a multiple problem is presented, an appointment is made for the group clinic, depending on the urgency of the situation and the patient's convenience. Emergencies are seen immediately and others are usually seen within one, two or three days.

When the patient arrives for the group clinic appointment, all necessary clerical work relating to the visit has been done. The medical history—if there is one—has been located and is sent to the clinic just prior to the patient's appointment time.

The patient is then seen by whatever number of doctors is needed to solve the problem. The student takes part in the consultation.

Between 25 and 30 new group clinic patients are seen each day from 8 a.m. to 1 p.m., Monday through Friday.

The brief experience with the group clinic thus far has indicated the need of about 20 physicians and surgeons and from five to seven specialists to conduct the examinations each day.

Each group clinic patient receives a chest x-ray examination, blood counts, Wassermann test and urinalysis. Whatever other tests are indicated in the specific cases are ordered by the consulting doctor.

"In effect, the new plan brings the various clinics—medicine, surgery and specialty—to the patient rather than have the patient visit one clinic one day, another the next, and so on," Dr. Crosby stated. "It also produces the important advantage of bringing all doctors concerned with the problem together at one time, with resultant advantage for the patient and for the student.

"The appointment system is essential to the smooth operation of the clinic, from both the hospital and patient standpoint. It is hoped that the group clinic appointment system will be developed into a uniform appointment schedule for all the clinics of the outpatient department."

Col. Liston Heads New Army Medical Center

WASHINGTON, D. C.—The Secretary of the Army has announced the appointment of Col. David E. Liston as commanding officer of the new Army Medical Center which was activated at Fort Totten, N. Y., on November 1.

Fort Totten Medical Center will consist of a center headquarters, Fort Totten General Hospital having an ultimate patient capacity of 300 beds, the experimental equipment laboratory and the laboratory and shop branch of the Army-Navy Procurement Office. The patient capacity of 300 beds will consist largely of temporary facilities. Plans are being considered for the construction of a new 1500 bed general hospital to provide general hospital and debarkation facilities needed in the New York area.

Issues New Bulletin

CINCINNATI.—The first issue of the *Christ Hospital Medical Bulletin* was published by the hospital staff last month. The bulletin will be published quarterly by the staff to present original papers embodying clinical observations or other studies made by the staff or by the members of the research institute, according to the initial announcement by Dr. M. F. Steele, hospital superintendent.

Merry Christmas to the Treasurer of your hospital too, who may decide to redeem the coupons in cash.

Merry Christmas to your patients who will undoubtedly get a psychological boost when they are served the cereals they eat in their own homes.

And, finally, *Merry Christmas* to the Dietitian who will be happy to know that the following food values are contained in the average ounce servings of Post's Individual Cereals with sugar and milk.

Calories	**210.**	**grams**
Protein	**7.0**	**grams**
Fat	**5.1**	**grams**
Carbohydrate	**33.**	**grams**
Calcium	**150.**	**milligrams**
Phosphorus	**210.**	**milligrams**
Iron	**1.7**	**milligrams**
Thiamine	**0.18**	**milligrams**
Riboflavin	**0.25**	**milligrams**
Niacin	**1.8**	**milligrams**

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GENERAL FOODS

Mississippians Discuss Blue Cross, Medical Plans at Meeting

JACKSON, MISS.—Dr. W. H. Parsons of the Vicksburg Clinic took office as president of the Mississippi Hospital Association at the annual meeting in Jackson, October 16-18, succeeding Dr. Henry Boswell of the state tuberculosis sanatorium who became a member of the association's board of directors. John Gill, administrator of the Street Clinic, Vicksburg, was named president-elect and Grace M. Golden of Mercy Hospital, Vicksburg, was reelected secretary-treasurer. Dr. L. B. Morris of Macon and Dr. Fred Van of Corinth were elected to the board of directors.

Discussion of the newly organized Blue Cross and Medical Service plans for Mississippi occupied a large part of the attention of more than 50 hospital administrators who attended the meeting. Richard G. Williams of Jackson was appointed secretary and executive director for Mississippi Hospital and Medical Service, the Blue Cross organization which has been approved by the American Hospital Association and the American Medical Association and will begin operations as soon as approval of the state insurance commission is received.

Speaking on modern anesthesiology, Dr. John Adrianni, Charity Hospital, New Orleans, said many surgeons do not want competent medically trained anesthetists in the operating room for fear their mistakes will be observed. He also criticized some hospitals for collecting large anesthesia fees and paying salaried medical anesthetists less than the amount collected, using the "profits" thus accumulated to offset deficits in other departments.

"Anesthesiology is a real medical specialty and requires postgraduate residency training similar to that in other specialties," Dr. Adrianni declared. He deplored the attitude of some hospital administrators who have resisted the organization of first class medical anesthesia departments headed by specialists. Dr. Adrianni pleaded for a major effort to direct more young doctors into anesthesiology. He stated frankly that he does not agree with many of his colleagues who oppose all nurse anesthetists. On the contrary, Dr. Adrianni said, there is a place for well trained nurse anesthetists to work along side their medical colleagues.

Responsibility for training nurses, at least until an adequate nursing corps to staff all Mississippi hospitals is available, should be assumed by the state, Dr. D. V. Galloway of Jackson declared. Just as the state assumes responsibility for training teachers and others whose function involves the community welfare, Dr. Galloway said the state must see to it that enough young girls are trained to become nurses to assure adequate care of hospital patients and others needing nursing service. Dr. Galloway, who is director of the Mississippi commission on hospital care, described the Mississippi state hospital plan which was among the first to be completed in the federal hospital construction program under Public Law 725.

Rember Heads A.M.A. Public Relations Staff

CHICAGO.—Lawrence W. Rember, formerly director of public relations for the Blue Cross Commission, has been appointed executive assistant in charge of public relations of the American Medical Association, Dr. George F. Lull, association secretary and general manager, announced last month. Mr. Rember fills the vacancy created several months ago by the resignation of Charles M. Swart.

Mr. Rember is a graduate of the University of Wisconsin and received the master's degree of journalism at Northwestern University.

Dr. Lull also announced appointment of Theodore R. Sills and Company of Chicago as public relations counsel for the association.

Atomic Commission Names Interim Head of Biology Division

WASHINGTON, D. C.—Dr. Shields Warren will serve as interim director of the newly created Division of Biology and Medicine of the U. S. Atomic Energy Commission, it was announced here October 24. Dr. Warren will retain his present connections as pathologist at New England Deaconess Hospital, Boston, and assistant professor of pathology at Harvard. He will continue also as director of the Massachusetts State Tumor Diagnosis Service.

Dr. Warren will serve on a half time basis until a permanent director is appointed. The interim director is the author of "The Effects of Radiation on Normal Tissues." He was chief of the naval medical field team investigating the effects of the bombing of Hiroshima and Nagasaki and was in charge of the pathological studies of the animals exposed to radiation in both Bikini tests. He is a member of the committee on pathology and the atomic casualty commission of the National Research Council.

The A.E.C. Division of Biology and Medicine will serve in correlating the broad programs of medical and biological research in both A.E.C. and private laboratories and institutions. It will likewise direct the health physics work and the industrial hygiene activities of the commission. This sixth programmatic division of the organization was recommended by the commission's medical board of review. The other divisions are research, engineering, production, military application and raw materials.

V.A. Outlines Technic Used in Preventing Spread of Tuberculosis

WASHINGTON, D. C.—Veterans Administration's tuberculosis service is not missing any bets in its efforts to prevent the spread of the disease, according to a résumé of its aseptic technic issued October 21. The program includes the utilization of extensive handwashing facilities in each tuberculosis ward and the wearing of caps, gowns and masks by personnel working with patients. Nurses have received special training in aseptic technic and are teaching other hospital nurses and attendants.

The use of germicidal lamps to control air-borne infection in TB hospitals is receiving close study. Use of an oil emulsion in the treatment of blankets, bed linens and floors is being tried in V.A.'s hospital at New Bedford, Mass. If the method proves successful in the control of tuberculosis infection, it will be introduced in other hospitals.

Surgical Fee Plan Set for District

WASHINGTON, D. C.—Around 735 doctors have been enrolled here in a plan whereby the public may buy insurance against doctors' fees for surgical and maternity cases, the District Medical Society announced November 6. The service will include doctors' bills for hospital surgery and maternity cases in addition to such other expenses as x-ray tests, anesthesia and laboratory work. The plan was initiated earlier this year when an agreement was reached between the Medical Society and Group Hospitalization, Incorporated.

G.H.I. will enroll the subscribers and expects the first contracts to be in operation by April 1. The service will be limited for a time to subscribers of the present Group Hospitalization plan. Later, the service will be open to others.

The new service will cost 80 cents a month for an individual, $1.75 for a husband and wife and $2 for a family group. Present rates for hospital services are 65 cents, $1.50 and $1.75. These rates have remained unchanged for the last ten years but they will probably be raised next year.

V.A. Revises Hospital Plans, Specifications to Obtain Bids

WASHINGTON, D. C.—In an effort to obtain enough construction bids to enable work to begin immediately on the 17 Veterans Administration hospitals to be contracted for prior to January 1, Lt. Gen. R. A. Wheeler, chief of engineers, has announced that numerous revisions had been made in hospital plans and specifications. With the revision designed to reduce construction costs, it is expected that the work can be placed promptly under contract, General Wheeler explained. All bids will be awarded within thirty days of the opening date.

At the same time, General Wheeler stated that the requirement for Saturday, Sunday and holiday work has been eliminated. By eliminating this requirement, which previously had been carried in all corps of engineers specifications to expedite work on the hospitals, contractors will now be able to figure with more certainty on labor costs. It will, in effect, establish a forty hour week for this class of work and eliminate premium payments for overtime.

These and other changes were made to meet the objections of contractors who might be reluctant to rebid on projects previously advertised. The new thirty day award clause is considered important inasmuch as the corps of engineers previously has reserved the right on some hospital contracts to make awards within sixty days.

24 Physicians Awarded U.S.P.H.S. Fellowships

WASHINGTON, D. C.—Twenty-four men and women physicians from 12 states have been awarded fellowships for a year of graduate study in public health, according to a recent announcement of the Federal Security Administrator. The fellowships, administered by the U. S. Public Health Service, are supported by the March of Dimes fund of the National Foundation for Infantile Paralysis. The award winners were chosen from 44 candidates.

In addition to the nine months or so of academic study at an accredited school of public health, each Fellow will have three months of supervised field training in a state or local health department.

Those receiving awards this year make a total of 43 physicians who have received or who will receive professional public health training under a National Foundation for Infantile Paralysis grant of $228,400. The grant was set up to train physicians and engineers in public health during a two year period.

Cancer Grant to Colorado

DENVER.—A grant of $25,000 has been received by the University of Colorado Medical Center from the National Advisory Cancer Council of the U. S. Public Health Service, Dr. Ward Darley, director of the center, announced. The money will be used to establish a department for the teaching of early cancer diagnosis and treatment to medical students, interns, residents and practicing physicians, Dr. Darley said. Dr. John M. Foster Jr., professor of surgery at the University of Colorado Medical School, will head this activity.

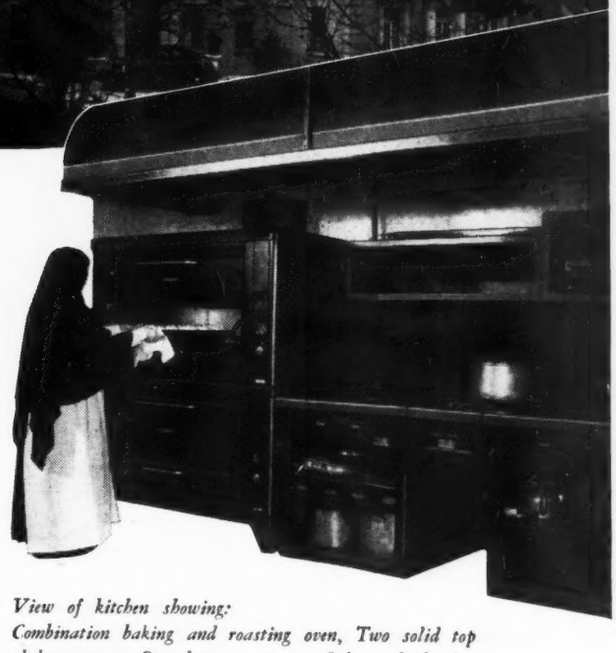
Plastic Dishes for Hospitals

WASHINGTON, D. C.—The Veterans Administration may have found the answer for hospital dishes in putting nylon to a new use, according to an announcement October 28. The plastic substance has been adapted to the manufacture of unbreakable dishes which may reach most of V.A.'s 126 hospitals by Christmas or a little later.

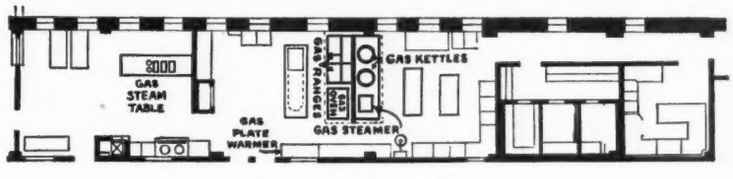
More than 105,000 pieces—including dinner plates, bread plates, fruit dishes, soup bowls and tumblers—will be purchased by the Veterans Administration through sealed competitive bids.

Mother Cabrini Memorial Hospital
163rd and Edgecombe Avenue, New York City

6500 EXTRA MEALS MONTHLY FROM EFFICIENTLY PLANNED GAS KITCHEN



View of kitchen showing:
Combination baking and roasting oven, Two solid top skeleton ranges, Open burner extension, Salamander broiler.



Layout of efficient Gas Kitchen

THE food service staff at Mother Cabrini Memorial Hospital is convinced of the flexibility and efficiency of Gas-fired Equipment in mass-feeding operations. When, after eight years' service, the original Gas Kitchen Equipment was called upon to provide 6500 extra meals monthly this increase required only the installation of a larger oven. With this single change the food service capacity was adequate for expansion from 150 to 200 beds at Mother Cabrini Memorial Hospital, which now serves 26,000 meals monthly.

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Illustrations—Courtesy G. S. Blodgett Co., Inc., Burlington, Vermont

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Francis J. Bean Elected President of Vermont Group

BURLINGTON, VT.—Dr. Francis J. Bean, superintendent of Putnam Memorial Hospital, Bennington, Vt., was elected president at a recent meeting of the Vermont Hospital Association, succeeding Laurence C. Campbell of Barre. Godfrey Crosby, superintendent of Brattleboro Memorial Hospital, was named vice president; L. E. Richwagen, superintendent of Mary Fletcher Hospital, Burlington, secretary and treasurer, and Mother Collins, superintendent at Bishop DeGoesbriand Hospital, Burlington, and E. S. Wright, trustee of Rutland Hospital, trustees.

Fay Crabbe, director of the University of Vermont department of nursing, told the association of the need for subsidizing nursing education, which, she said, has greatly increased in cost. Those giving nursing education should not be asked to shoulder this burden alone, she said, but perhaps the state should be asked to help pay costs as it does for students preparing for teaching of agriculture.

Army, Navy Doctors Due for Release

WASHINGTON, D. C.—Some 2200 medical officers trained at government expense during the war were due for release December 1, according to an army-navy announcement. Around 900 navy "V-12 class" doctors were affected by the order as well as 1300 nonvolunteer general duty army medical officers. All of them had entered the service prior to May 1, 1946. The shortage of army and navy doctors has kept them in service.

Both army and navy have encouraged these young medical officers to apply for commissions in the regular army or navy, or another year's active duty on a voluntary basis. If enough of the doctors do not remain on voluntarily, both services have reserved the right to retain a sufficient number to hold the medical departments at minimum strength.

Take Bids on V.A. Hospital

WASHINGTON, D. C.—Construction of a 150 bed addition to a V.A. tuberculosis hospital in San Fernando, Calif., had already come to the bid stage, Veterans Administration reported November 5. Other additions will be a connecting corridor, several utility buildings and more adequate facilities for the hospital infirmary.

Specifications for most of the construction calls for concrete foundations, reinforced concrete exterior walls with cement water paint exterior finish, reinforced concrete floors and tile and built-up roofs.

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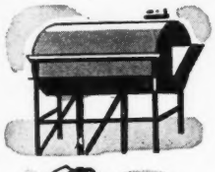

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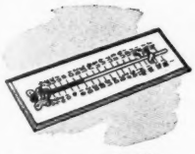

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Offers Help to Cancer Center Destroyed by Fire

WASHINGTON, D. C.—The U. S. Atomic Energy Commission offered prompt help October 29 to the nation's foremost cancer research center destroyed in the recent fire at Bar Harbor, Me. A.E.C. will provide funds, buildings and equipment for the reestablishment at Brookhaven National Laboratory on Long Island of the Roscoe B. Jackson Memorial Laboratory burned out in the forest conflagration.

The famous research center lost nearly all records and equipment. The commission's offer of a building and equipment for the laboratory and of temporary housing for a part of the staff of 40 was telephoned to Dr. Clarence C. Little, director of the Bar Harbor institution. A.E.C. has funds immediately available for this purpose from the fiscal year appropriation of $5,000,000 to assist cancer research outside the commission's program.

Dr. Shields Warren, director of the A.E.C. Division of Biology and Medicine, and Dr. Philip B. Morse, director of Brookhaven National Laboratory, said the research program directed by Dr. Little is directly related to the cancer research program authorized for Brookhaven. The Jackson laboratory, however, if moved to Brookhaven, would retain full independence, receiving only assistance and services from the latter.

The provision of quarters at Brookhaven has been offered on either a temporary or permanent basis.

Nine Elected to Mental Hygiene Group

NEW YORK.—Nine men and women from the fields of medicine, education, religion and business have been honored for outstanding contributions to the cause of mental health by election to membership in the National Committee for Mental Hygiene, Dr. George S. Stevenson, medical director, announced yesterday.

They are Gen. Paul R. Hawley, chief medical director, Veterans Administration, Washington; Dr. Charles A. Dickinson, head of the department of psychology, University of Maine, Orono; Dr. Robert M. Goldenson, assistant professor of psychology, Hunter College, New York; Lawrence K. Frank, director, Caroline Zachry Institute of Human Development, New York; Margaret H. Wagenhals, assistant editor of *Mental Hygiene,* New York; the Reverend Otis R. Rice, chaplain and director of religion, St. Luke's Hospital, New York; the Reverend Rollin J. Fairbanks, executive director, Institute of Pastoral Care, Massachusetts General Hospital, Boston; Percy C. Magnus, vice chairman of the board of the combined Beekman-Downtown Hospital, New York, and Benjamin P. DeWitt, attorney, New York.

Freer Named to V.A. Post

WASHINGTON, D. C.—Appointment of Dr. Arden Freer as deputy medical director of Veterans Administration was announced October 30. Dr. Freer succeeds Dr. Robert C. Cook who requested transfer to Colorado, where he will be manager of the V.A. hospital at Fort Logan. Dr. Cook who has been Dr. Hawley's assistant since early 1946 had much to do with the reorganization of veterans' medicine in V.A. hospitals.

During World War II, Dr. Freer was awarded the Legion of Merit for service as chief of medical service and later executive officer at Walter Reed General Hospital; the Distinguished Service Medal, for his work as chief of professional administrative service, Surgeon General's Office, and the Army Commendation Ribbon in recognition of his work as director of the medical consultants division, Surgeon General's Office.

Iowa Association Urges Compliance With Federal Rules

IOWA CITY, IOWA.—Expressing concern that administrative delays might disqualify the state for participation in the Federal Hospital Survey and Construction program, the Iowa Hospital Association last month passed a special resolution urging elimination of "every possible administrative barrier which now constitutes a block between the state of Iowa and the U. S. Public Health Service in the eligibility to receive federal funds."

The association's resolution which was forwarded to Gov. Robert Blue and Dr. Walter L. Bierring, state health commissioner, pointed out that waiting lists for admissions to hospitals exist in the state and that Iowa hospitals are overcrowded and in many instances using obsolete facilities.

"The association has no intention of embarrassing either Governor Blue or Dr. Bierring in proposing the resolution," Gerhard Hartman, president, said. "Its purpose is to set forth the health needs of the state that are jeopardized by administrative impasses," he added.

53,000,000 Chest X-Ray Films Held by V.A.

WASHINGTON, D. C.—The Veterans Administration is the custodian of 53,000,000 army chest x-ray films of World War II veterans, the administration announced October 21. The films, which include those made of each army veteran at the time of induction and separation, comprise the largest single group of x-ray films in the world. The films will assist V.A. in its study of tuberculosis among veterans and will be available for determining eligibility of veterans for compensation.

A "central case register" of all World War II veterans who were discharged from the armed forces because of tuberculosis has been established. This register enables the outpatient tuberculosis clinics of V.A. regional offices to keep in close touch with each veteran who contracted tuberculosis while in the service. Combined with the information on the millions of x-ray films, the register will be of assistance in the long range study of the disease among the veteran population.

Hospital for Crippled Children

SOUTH BEND, IND.—Ground has been broken for construction of a Northern Indiana children's hospital here. The hospital is being built on an 11 acre site adjacent to the University of Notre Dame campus. The hospital will have 100 beds and will provide care for crippled children from northern counties in Indiana. An isolation unit for poliomyelitis is included in the plans. Alvan A. Sauer is the hospital superintendent.

COMING MEETINGS

ASSOCIATION OF WESTERN HOSPITALS, Biltmore Hotel, Los Angeles, April 19-22.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Roanoke Hotel, Roanoke, Va., April 15, 16.

CATHOLIC HOSPITAL ASSOCIATION, Cleveland Public Auditorium, Cleveland, June 7-10.

NEW ENGLAND HOSPITAL ASSEMBLY, Silver Jubilee, Hotel Statler, Boston, March 15-17.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Bellevue-Stratford Hotel, Philadelphia, April 28-30.

IOWA HOSPITAL ASSOCIATION, Hotel Fort Des Moines, Des Moines, April 24.

NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Hotel Gibson, Cincinnati, Feb. 18, 19.

NATIONAL EXECUTIVE HOUSEKEEPERS' ASSOCIATION, Denver, June 23-26.

NEW JERSEY HOSPITAL ASSOCIATION, Hotel Dennis, Atlantic City, N. J., May 20-22.

OHIO HOSPITAL ASSOCIATION, Deshler-Wallick Hotel, Columbus, April 6-8.

SOUTHEASTERN HOSPITAL ASSOCIATION, Biloxi, Miss., April 22-24.

TEXAS HOSPITAL ASSOCIATION, Dallas, March 4-6.

Colorado Medical Center Has New Approach to Medical Education

DENVER.—A new approach to medical education is being put into operation for the first time in the Rocky Mountain region at the University of Colorado Medical Center here, it was revealed recently.

The new curriculum is the result of study and plans made by medical school faculty committees appointed last year, Dr. Ward Darley, director of the center, said. The program is designed to meet the primary medical need of the state for more general medical practitioners.

In addition to emphasizing a broad premedical background and medical skills, the modernized program stresses the broader aspects of medical practice, such as the importance of a doctor's relationship with his patient, with the community and with society at large, Dr. Darley explained. Through supervised clinical work and through discussions with practicing physicians and visiting specialists, students can correlate their classroom theory with real life experience, he said.

The new curriculum at the University of Colorado Medical Center is just now getting under way, but the attention of medical schools across the country is being focused upon the pioneering efforts to improve medical training for prospective doctors, Dr. Darley declared.

V.A. Hospitals Speed Treatment of Veteran Patients

WASHINGTON, D. C.—Reception services in Veterans Administration hospitals are being abolished to speed active medical treatment of veteran patients, Dr. Paul R. Hawley, chief medical director, announced November 10.

All general medical and surgical patients will be admitted directly into active treatment wards where case histories, necessary x-ray and other routine examinations will be made. In tuberculosis hospitals, new patients will enter diagnostic and classification units where they will be put to bed immediately. In neuropsychiatric hospitals, acute (intensive treatment) services are being established and treatment programs will be started without delay.

A peak of 52,030 World War II veterans receiving hospital care from the Veterans Administration was reached on August 1.

1600 Public Health Nurses

WASHINGTON, D. C.—Some 1600 nurses, slightly less than the total authorized strength, are now on duty in the Public Health Service, Dr. Thomas Parran's office revealed here recently. Of this group, 134 are regular corps officers, 336 are reserve corps officers and 1044 are civil service appointees. The greatest number of public health nurses is assigned to the service's 24 hospitals, the largest of which is located at Staten Island, N. Y. Public health nurses are encouraged to specialize in many fields, such as cancer control and mental hygiene. The Division of Nursing is accepting applications both for the commissioned corps and for civil service appointments.

R. I. Plan Hits New High

PROVIDENCE, R. I.—"Rhode Island Blue Cross enrollment has reached a new all time high," Kenneth D. MacColl, Blue Cross president, announced at a recent meeting. He reported a total enrollment of 518,746 members and said it represented 74 per cent of the total eligible population of the state. The Rhode Island plan continued to have the greatest percentage of enrollment among the 88 hospital care plans in the country.

Protein Nutrition Need Not Suffer In This Present Situation

The erroneous belief still prevails in many lay minds that choice grades of meat are nutritionally superior to the less costly grades. By dispelling this error, much can be accomplished to encourage an adequate intake of high quality protein in the daily dietary.

The less expensive grades of meat are at least the equal of the choice grades as sources of the amino acids indispensable for growth, tissue repair and virtually every vital process. In these lower grades the muscle bundles which constitute the protein bulk of meat are not separated by layers of fat as is the case with the choicer grades. Hence, on a weight for weight basis, less expensive grades tend to provide slightly higher percentages of protein. Properly prepared, these meats can be just as tender and as easily digestible as the choicer grades, and may be served in any diet in which meat is indicated.

By promoting the use of the less expensive grades and cuts of meats, the quality of protein nutrition can well be maintained in the nation's dietary.

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60,000 Disabled Persons Rehabilitated in 1947, O.V.R. Reports

WASHINGTON, D. C.—The year will bring full rehabilitation to 60,000 disabled men and women if the present rate of increase is maintained in the number of disabled citizens fully rehabilitated into self sustaining employment, Michael J. Shortley, director of Vocational Rehabilitation, said November 3. A 36 per cent increase in the number was registered in the first quarter of the fiscal year in the federal-state system of vocational rehabilitation for civilians.

Civilian men and women with disabilities which handicap them in obtaining or performing suitable jobs are eligible, through their state divisions of vocational rehabilitation, for diagnostic examinations, medical, surgical, psychiatric and hospital care. They are eligible also for counsel and guidance, training, maintenance and transportation. Customary occupational tools and equipment are furnished them, they are placed in the right job and the necessary follow-up is made to ensure that they make good.

Eye Bank Offers Fellowships

NEW YORK.—Fellowships for research in ophthalmology have been granted to the Harvard and Yale university medical schools by The Eye Bank for Sight Restoration, Inc., it was announced here by Mrs. Aida de Acosta Breckinridge, executive director. Recipients of fellowships will devote themselves chiefly to problems related to the cornea. It is expected that the knowledge thus acquired will aid in the conservation of vision and the restoration of sight among thousands of individuals. One of the principal objectives of research carried on at the present time is the discovery of a method for the preservation of corneal tissue for a period longer than seventy-two hours.

Apartments for Employes

NEW YORK.—Accommodations for some 200 employes who must live near the hospital have been provided in a 12 story apartment house adjacent to Columbia-Presbyterian Medical Center, New York City. Known as the Edward S. Harkness Memorial Hall this includes 184 one, two and three room apartments, all completely furnished and with modern kitchens. It will be occupied by 160 nurses and 40 other hospital technicians both men and women. Rates are $35 for one room, $60 for two and $80 for three rooms, including gas and electricity. A tunnel connects the apartment house with other units of the medical center for the convenience of the staff.

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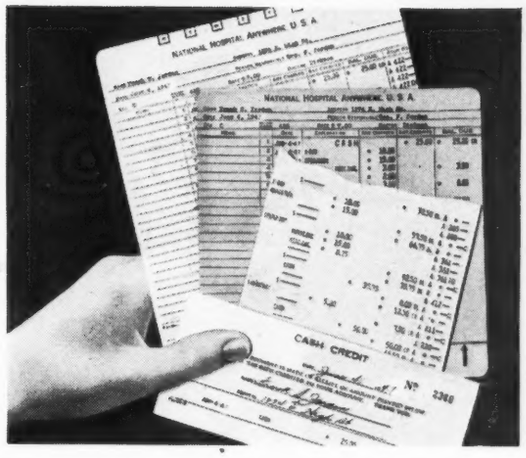

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Southern Institute for Administrators to Be Held in March

CHICAGO.—Harold C. Mickey, superintendent of Duke Hospital, Durham, N. C., will direct the second Southern Institute for Hospital Administrators, to be held at Duke March 22-27, according to an announcement from the American College of Hospital Administrators. In addition to the college and Duke University, the Carolinas-Virginias Hospital Conference and Southeastern Hospital Conference are sponsoring the institute.

Morning and afternoon sessions will be held in the university buildings, and one afternoon will be devoted to field trips to hospitals and clinics in the area, Dean Conley, college secretary, explained. Evening features include a barbecue, banquet and informal discussion groups.

General topics to be covered are basic principles underlying efficient hospital administration, fundamental functions of hospitals, professional staff organization, fundamentals in hospital planning and legal aspects of hospital administration, the announcement said.

Eligible to attend the institute are administrators or administrative assistants of recognized hospitals.

New York State Nurses Honor John McCormack

NEW YORK.—John McCormack, superintendent of the Presbyterian Hospital and former president of New York Hospital Association, was honored by the New York State Nurses' Association at a recent meeting here when the nurses passed a resolution commending his devotion to the "improvement of personnel practices."

According to the resolution, Mr. McCormack devoted countless hours to the interests of nurses during his terms of office as president of the state association and president of the Greater New York Hospital Association. "His advice and guidance have been of inestimable value," the nursing group's resolution stated. "His philosophy and practical application of the principles of sociology and economics have permeated far beyond the boundaries of Greater New York and have influenced the thought and actions of other hospital administrators throughout the state."

The resolution expressed appreciation to Mr. McCormack for his "friendly and understanding support."

Issues Call for More Practical Nurses

NEW YORK.—Sixty-five per cent of all nursing duties can be performed by practical nurses, Dr. J. J. Golub, superintendent of the Hospital for Joint Diseases, declared recently in issuing a call for additional enrollees in the hospital's school of practical nursing.

"The shortage of nurses in hospitals and in private practice has become acute," Dr. Golub said. He urged "the immediate recruitment and training of additional practical nurses as a key answer to this shortage."

"With the existing shortage of nurses of all types, including registered nurses, we often find the registered nurse engaged in nursing details that do not properly call for her services. At the same time, nursing areas where her skill is required are neglected," Dr. Golub said. "A study recently completed at our hospital shows that 65 per cent of all nursing procedures can be performed by the practical nurse. Present courses in practical nursing enable her to undertake these procedures on a high level of competence."

With the completion of its third year, the school will have graduated more than 150 women into the practical nursing field, Dr. Golub said. About half of its past graduates have remained in the hospital, "and," he added, "the patients love them. They have made themselves indispensable in the care of the sick. Practical nursing has at last come into its own."

Voluntary Service Hospital Group Meets

WASHINGTON, D. C.—Representatives of 24 national organizations comprising the National Voluntary Service Hospital Advisory Committee met with the Veterans Administration officials here November 12. The orientation and indoctrination program for volunteer workers in V.A. hospitals was the principal topic on the agenda.

Coordination of the entire voluntary service plan is handled by the Voluntary Service Hospital Advisory Committees at the national, branch and hospital levels. Representatives of 24 groups recognized at the national level are members of the national committee. Approximately 300 organizations are cooperating in the plan at the hospital level throughout the country.

Volunteer workers fall into four general classifications of activities at V.A. hospitals:

1. Medical rehabilitation: Duties range from acting as escorts for blind and wheel chair patients to assisting instructors in occupational therapy.
2. Special services: Serve as group instructors and leaders for hobby clubs, dramatics, musical and sports programs.
3. Social service: Act as language interpreters and assistant V.A. social workers in half a dozen other varied tasks.
4. Nursing service: Serve as nurse's aides.

Such workers are given a thorough orientation and indoctrination course in addition to training-on-the-job under the supervision of professional V.A. employes. Details of courses are arranged at the hospitals, but each must meet certain standards established at the national level.

Schedule Institute on Nurse Education

CHICAGO.—Designed to bring hospital administrators and nursing school leaders together for a discussion of nursing education, an institute on nursing will be conducted jointly by the American Hospital Association and the National League of Nursing Education in Chicago, March 1 to 5.

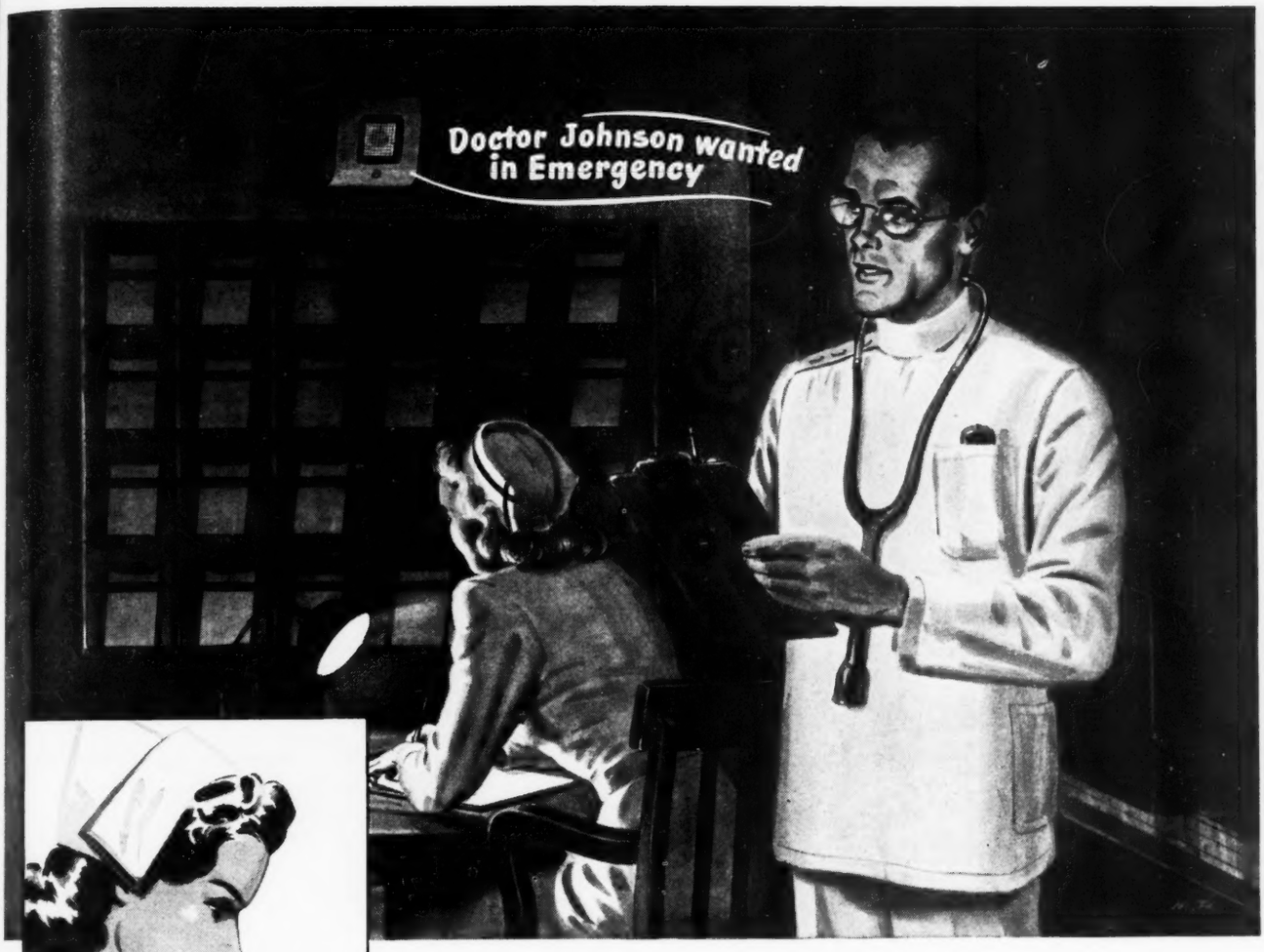
Requirements for the administration of a good school of nursing will be discussed by hospital administrators, physicians, directors of schools of nursing and other educators. Program topics will include the rôle of the auxiliary worker in hospital service, curriculums of hospital nursing schools and organization, administration and financial support of a basic program in nursing education. In addition to lectures by the faculty, there will be a group discussion by registrants of issues relating to nursing.

Enrollment at the institute will be limited to 50 hospital administrators and 50 directors of schools of nursing. Registrants must be personal members of the American Hospital Association or the National League of Nursing Education, or representatives of institutional members of the American Hospital Association.

To Build 530 Bed Hospital

CLEVELAND.—A new hospital for the Apple Creek State School, Apple Creek, Ohio, has been designed for 530 beds and will serve as both a general and mental hospital, Joseph A. Gattozzi, architect, announced recently. Plans include a four story center section with two wings and a T-shaped extension.

Architect's rendering of Apple Creek Hospital.



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Hospital as Health Center to Be Stressed at Dietary Institute

CHICAGO.—An institute on planning and administration of the hospital dietary department will be conducted by the American Hospital Association in St. Petersburg, Fla., January 12 to 16. Sponsored jointly by the association's council on professional practice and the council on hospital planning and plant operation, the institute will give special emphasis to the hospital as a health center, a headquarters announcement said.

Nutrition as an aspect of community health; construction and planning details for the food service; problems in remodeling or expansion of present facilities; new approaches to special diet service, and management procedures in employe training, food production, food cost control, sanitation and the preparation of infant formulas will be discussed.

Enrollment is open to administrators, assistant administrators, dietitians and instructors in institution management. Applicants must be employed by hospitals which are members of the American Hospital Association, personal members of the association or instructors in universities or colleges preparing students for approved dietetic internships.

Proposes Survey of Illness Cost in D. C.

WASHINGTON, D. C.—Theodore Wiprud, secretary of the District Medical Society, met with the Area Hospital Council here November 19 to explore the possibilities of initiating an exhaustive survey of hospital expenses in the District. Mr. Wiprud has long had under consideration the making of a study of costs to hospitalized patients—all costs as against their incomes.

If the study is approved, the committee on medical care of the District Medical Society will probably ask the U. S. Public Health Service to carry out a survey of hospital expenses in the whole metropolitan area. Such a survey would cover doctors' fees, special nurses, medicines, anesthetics, operating room costs and innumerable other items.

Hypertension Clinic Opens

NEW YORK.—A hypertension clinic has been established at the Bronx Hospital in connection with the presently functioning vascular medical clinic, Dr. A. A. Karan, director, announced last month. This new clinic service has been instituted for the purpose of evaluating current methods of treatment of hypertension, including the selection of patients for the surgical treatment of hypertensive disease, Dr. Karan stated.

Professional Standards Department Proposed

WASHINGTON, D. C.—Recommended changes in the government of the District embrace the setting up of a department of professional and occupational standards, according to a preliminary report issued November 2 by a House subcommitee. The nurse examining board would come under such a department. The present ex officio members of the Commission on Licensure, Healing Arts Practice and the Board of Podiatry Examiners would be abolished and the director of the Department of Health would serve as chairman ex officio of both boards.

The subcommittee does not propose, according to the preliminary report, to disturb the present intent of the laws to have persons examined and qualified for engaging in professions or skilled occupations by boards composed of members versed in those professional occupations. Grouping them together in one department would result in some economy without any loss to the professions or occupations concerned, said the report.

The professional boards all now subsist upon their own fees, make their own expenditures and generally govern themselves.

National Health Is at High Level

WASHINGTON, D. C.—The general health of the people of the United States, maintained during the war years at a higher than prewar level, continued favorable during the first six months of 1947, Federal Security Administrator Oscar R. Ewing declared in a recent report.

The reported incidence of most of the important communicable diseases, the crude death rate, the maternal and infant mortality and the specific death rates for certain diseases indicate as good health conditions in the United States during the first half of 1947 as in 1946, if not slightly better, according to Public Health Service figures, Mr. Ewing pointed out.

Lower death rates for tuberculosis, pneumonia and influenza (combined), the common communicable diseases of childhood, and syphilis are estimated from sample figures. Although more cases of influenza were reported in the first six months of 1947 than for the same period in 1946, the estimated death rate for influenza and pneumonia (combined) for this period in 1947 was 55.8 per 100,000 population, or 5 per cent below the rate of 58.9 in 1946. The influenza epidemic appeared later than usual in 1947, beginning the latter part of February or early in March.

Pharmacists to Meet

BIRMINGHAM, ALA.—Hospital pharmacists from six southeastern states will hold a meeting in Atlanta during January 1948, Joe Vance, publication chairman of the Southeastern Hospital Pharmacy Association, has announced. The meeting will precede the regular annual program held in conjunction with the Southern Hospital Conference in April. Paul Rees of Washington, D. C., who served in the navy hospital corps for a number of years and was active in research work on blood therapy during the war, will be the principal speaker at the January meeting, the announcement said.

Consultants to Army Library

WASHINGTON, D. C.—The following were recently appointed honorary consultants to the army medical library by Surgeon General Raymond W. Bliss: Dr. John E. Gordon, professor of epidemiology, Harvard School of Public Health; Maj. Gen. Norman T. Kirk, retired, former Surgeon General, U. S. Army; Tracy S. Voorhees, LL.D., special assistant to the Secretary of the Army.

Issue Joint Army-Navy Medical Supply Catalog

WASHINGTON, D. C.—Tangible evidence of army-navy unification under the new Office of National Defense is the first joint army-navy catalog of medical material issued during October. It supersedes the separate army and navy medical supply catalogs in use heretofore. Every army and navy medical and hospital facility will have a copy of the new catalog when distribution is completed.

In recognition of the simplified thoroughness of the new catalog, the U. S. Public Health Service and the Veterans Administration have indicated that they will adopt a similar style in their future catalogs. The ultimate result may be a single federal medical supply catalog with provision made for special designation of those items utilized by only one service, comparable to the army-only and navy-only listings in the present volume.

The 7823 items listed range from penny-class expendables, such as tongue depressors and dental burs, to therapeutic x-ray units in the $10,000 field. Items are divided by types into 14 classes. There are 5026 JAN items—items adaptable for both army and navy use. In addition, there are 1581 army-only and 373 navy-only entries. The remainder of the listings are "limited service" supply which means their procurement and allocation are in process of gradual discontinuance.

The first printing of the new volume ran into 16,000 copies. The task of composing it was initiated by former Surgeons General Norman T. Kirk of the U. S. Army and Ross T. McIntire of the U. S. Navy. It has been completed under the supervision of their successors, Surgeons General Raymond W. Bliss and Clifford A. Swanson.

American Hospitals Lead in Food Planning, British Expert Says

LONDON.—America is years ahead of Great Britain in intelligent planning and spending for hospital food service, Margaret Broatch, dietetic adviser to the King Edward Hospital Fund, reported, following an extensive tour of hospitals in the United States from which she has recently returned.

Miss Broatch praised American hospitals for their use of labor saving devices wherever possible and for providing additional kitchen equipment space and personnel whenever hospital beds are added.

The practice of offering menus to patients and allowing them a choice of dishes is generally carried out for private patients in American hospitals but not in wards, Miss Broatch reported. In the London hospital, it was pointed out, a dietitian regularly visits ward patients to discuss their food preferences.

During the war, Miss Broatch served as a consultant for hospitals in food service management and dietetics. She is known as Britain's leading authority on hospital dietetics.

Doctors Hospital Graduates First Class of Nurse's Aides

WASHINGTON, D. C.—Doctors Hospital which started training girls here about a year ago as nurse aides bestowed aide caps, uniforms and pins on the first group of girls so trained in graduation exercises November 2. Sixteen members of a second group have started the year's training.

The course has been somewhat revised. Three months of classroom work is now required instead of four and a corresponding increase has been made in the amount of practical work in caring for patients and in the hospital laboratories.

The students will be paid $25 a month for their first three months' training, $50 a month for six months, and $75 a month for the last three months. In addition, they receive free laundry, textbooks and meals while on duty. The aides work a six day, 48 hour week. They must be between 18 and 35 years of age. They may be single or married but must have no dependents.

Study Infant Feeding

CHICAGO.—Rigidly prescribed routines of infant feeding will meet the requirements of the average baby but cannot possibly fit the needs of babies whose natural rhythm deviates naturally from the average, according to a study of the "self-regulating" method in feeding babies published in the *Journal of the American Medical Association*. The study was conducted by Dr. C. N. Aldrich, director of the Rochester, Minn., Child Health Project, and Dr. Edith S. Hewitt, a member of the project staff. Doctors Aldrich and Hewitt based their conclusions on a study of more than 600 infants.

21,000 Patients Cared for

NEW YORK.—Long Island College Hospital served more than 21,000 patients during the last year at a cost of $1,400,000, according to the hospital's 88th annual report released last month. The hospital rendered 125,366 days of patient care in addition to 58,630 clinic visits, the report said. An average loss of 36 cents per patient day was reported.

ABOUT PEOPLE

(*Continued From Page 82.*)

to the institution. Mr. Overland has been administrator of the hospital since 1935.

John R. Howard, superintendent of Muhlenberg Hospital, Plainfield, N. J., for the last twelve years, submitted his resignation in November because of ill health. Mr. Howard went to Muhlenberg Hospital from New York Hospital. He had previously been head of New York Orthopedic Hospital. **Frank P. Sauer,** assistant superintendent, succeeds Mr. Howard.

Department Heads

Lillian H. Erickson has resigned her position as field director of the extension courses for medical record librarians to accept a position with the United States Public Health Service in Washington, D. C.

Marian Ellingwood, R.N., has joined the University of Nebraska School of Nursing, Omaha, as director of student health and instructor in public health.

Hilda Helmke, R.N., has assumed her new duties as assistant director of the school of nursing at the University of Nebraska Medical College, Omaha.

Bruce L. Clark, formerly administrator of King's Daughters' Hospital, Portsmouth, Va., has been named director of purchases at the Medical College of Virginia. Previously Mr. Clark was purchasing agent at Miami Valley Hospital, Dayton, Ohio, and director of City Hospital, Parkersburg, W. Va. In his new position, which he started November 1, Mr. Clark will coordinate and direct the purchasing for both the hospital and the college, working closely with the state department of purchasing.

Lelia Moore

Lelia Moore, R.N., has been appointed assistant director of nurses of the Long Island College Hospital, Brooklyn, N. Y., succeeding **Ann Weinschreider** who recently accepted the post of director of nurses at Brooklyn Eye and Ear Hospital. Prior to joining the staff of Long Island College Hospital, Miss Moore has been successively assistant director of nurses, Fitkin Hospital, Neptune, N. J., obstetrical supervisor at Queens Hospital, Honolulu, T. H.; administrator of the school of nursing, Margaret Hague Hospital, Jersey City, N. J.; assistant director at Woman's Hospital, New York City, and medical and surgical supervisor, Beth-El Hospital, New York City.

Miscellaneous

Leonard Goudy has joined the staff of the American Hospital Association as purchasing specialist.

Dr. Israel Weinstein has resigned as commissioner of health in New York City and has been succeeded by **Dr. Harry S. Mustard,** director of the Columbia University School of Public Health. Dr. Weinstein will retire from the department on June 1, 1948, and meanwhile will serve as director of the Bureau of Public Health Education in which he had previously served as assistant director.

Maj. Gen. Paul R. Hawley, chief medical director of the Veterans Administration, has been awarded the 1947 Gorgas Medal, sponsored by Wyeth, Incorporated, Philadelphia, for his outstanding achievement in reorganizing and directing the V.A.'s medical division. The medal was presented to General Hawley by the Association of Military Surgeons at its meeting in Boston on November 14.

Dr. George W. Hervey has been appointed director of the statistical division of the newly organized national blood program of the American Red Cross.

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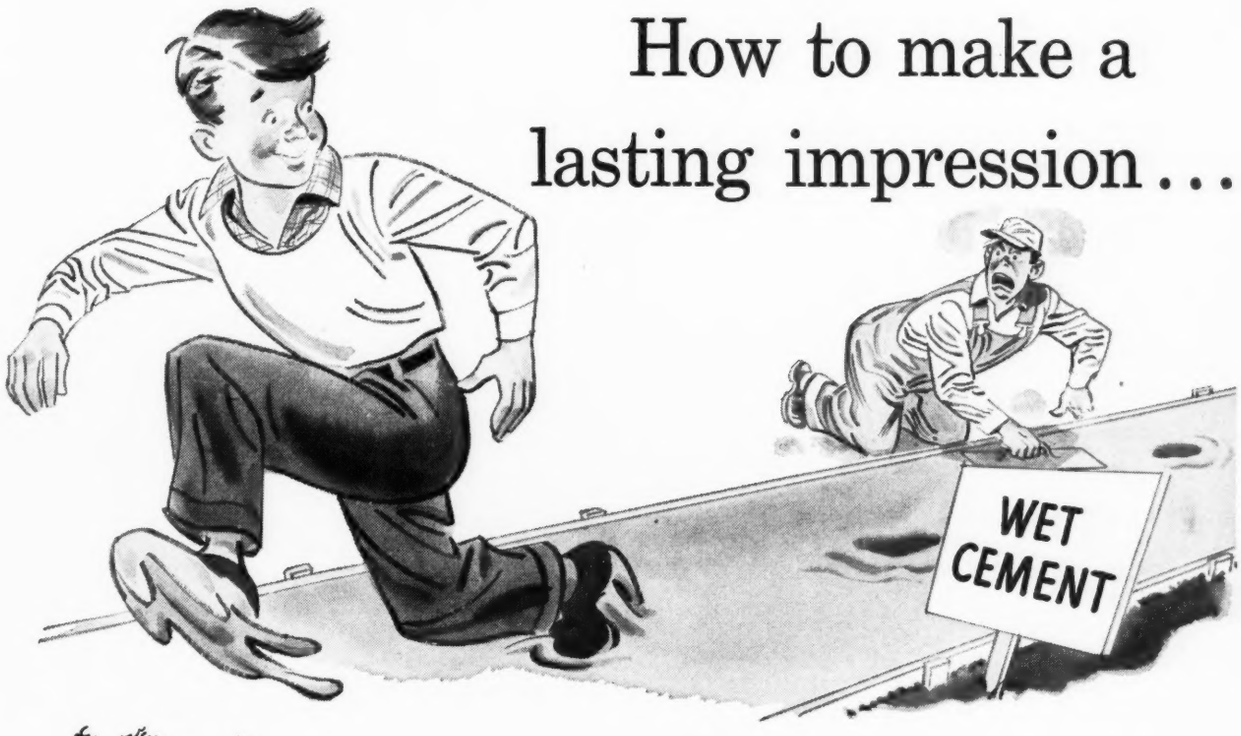
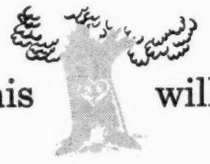


This  will last longer than this 

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Joseph Blumenkranz has been appointed by the War Department, corps of engineers, as hospital consultant under the nationwide construction program for the Veterans Administration. Mr. Blumenkranz has had considerable experience in the hospital field having served as architect and hospital consultant to the government of Puerto Rico, following several years as senior architect of hospitals with the city of New York.

Verne A. Pangborn, director of the Iowa State Hospital Survey and Construction Program, has resigned to accept the directorship of the Nebraska hospital program.

Deaths

Dr. Clarence O. Cheney, former president of the American Psychiatric Association and former medical director of the New York Hospital-Westchester Division, died November 4 of a cerebral hemorrhage at the age of 50. Dr. Cheney in 1936 became medical director of the Bloomingdale Hospital, White Plains, N. Y., which afterward was changed to the New York Hospital-Westchester Division. He served in that capacity until July 1, 1946, when he was succeeded by **Dr. James H. Wall.**

F. S. Durie, administrator of the University of California Hospitals, San Francisco, died of a heart attack early in October. Mr. Durie had been head of the institution since 1933.

James Philip, administrator of Palo Alto Hospital, Palo Alto, Calif., died suddenly October 25.

Mrs. Elizabeth Thompson, for the last six years assistant superintendent in charge of purchasing at Cooley Dickinson Hospital, Northampton, Mass., died recently.

Kenneth H. Gordon, assistant director, Woman's Hospital, New York City, died recently. Mr. Gordon had been associated with Woman's Hospital since March 1, 1946, following his release from the U. S. Navy. He has been succeeded by **Mary R. Meehan, R. N.**

Dr. William A. O'Brien, director of postgraduate medical education and professor of preventive medicine and public health at the University of Minnesota, died November 15 of a heart attack. Dr. O'Brien specialized in tuberculosis and cancer control.

The BOOKSHELF

INFANT CARE. *United States Children's Bureau Publication No. 8. Paper. Pp. 126. Price 15 cents ($11.25 per hundred copies).*

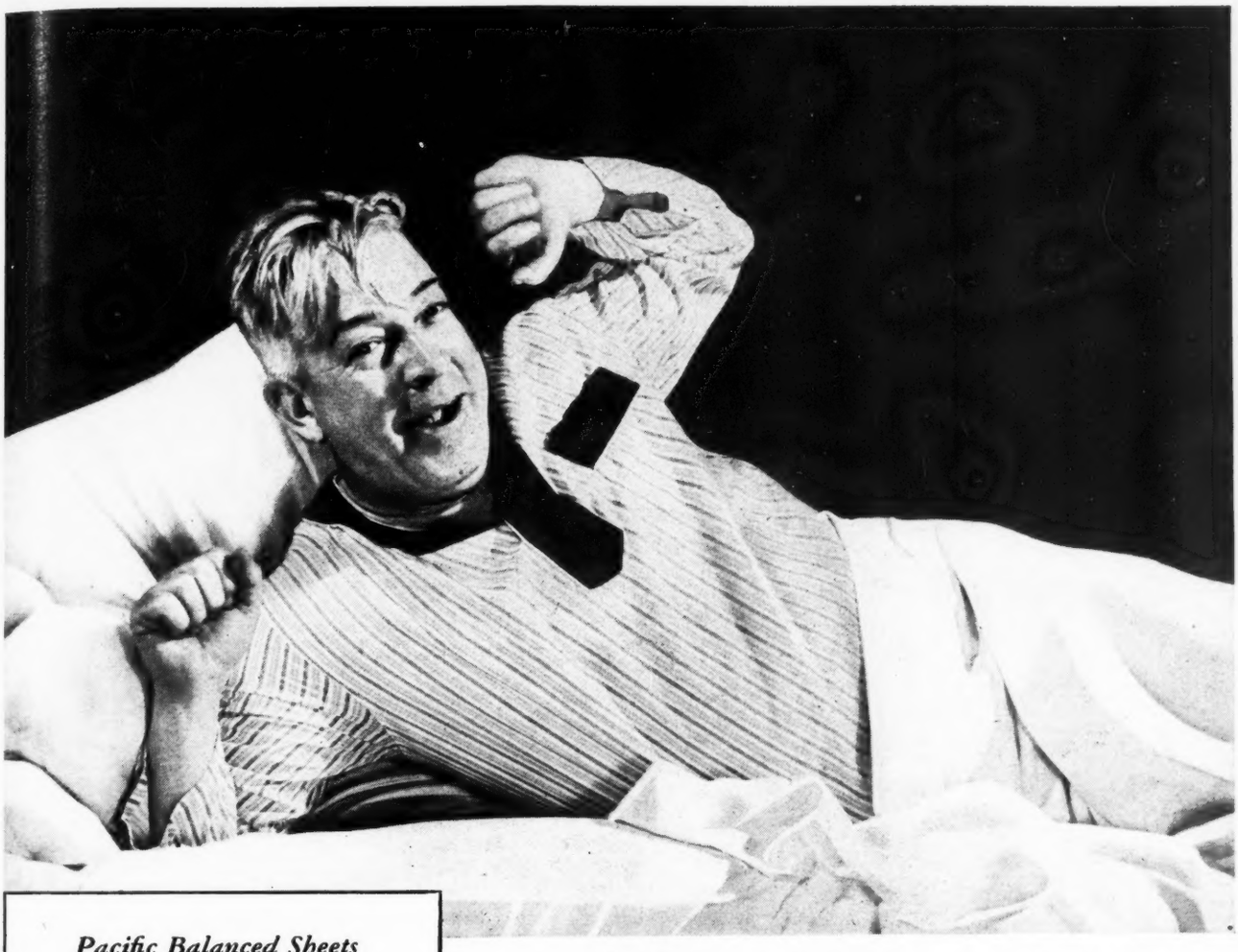
This recent edition of a pamphlet that the Children's Bureau has been publishing for several years was prepared by staff physicians and has the approval, according to the foreword, of such authorities as C. Anderson Aldrich of Rochester, Minn., Douglas Thom of Boston and Frederick Allen of Philadelphia.

The book includes all the information mothers should have, including selection of a doctor, preparing the home, baby's clothing and, of course, detailed instruction for feeding, bathing, protection, habit training and general care of the baby.

Tabular information and illustrations help make these instructions easy to read and understand.

Through its council on professional practice, the American Hospital Association has urged the desirability of wide distribution for this excellent pamphlet. Many state health departments now have supplies for distribution to hospitals on request.

"If every hospital would designate a member of the staff to be responsible for the distribution of this publication a day or two after delivery to all mothers of liveborn infants," says a joint statement signed by Katherine F. Lenroot of the Children's Bureau and Dr. Robin C. Buerki, chairman of the association's council on professional practice, "it would



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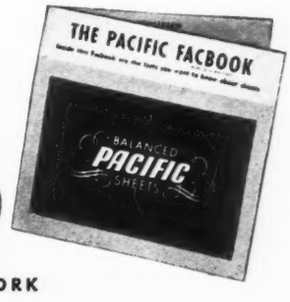

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mean that about 80 per cent of all mothers in the country would have this valuable health education material when they can read it with some leisure and be better able to refer to it upon their return home.

"If you are not already distributing this publication," continues the statement, which is addressed to hospitals, "we urge you to write to your state health officer today and determine whether he can make copies available to you each month. If sufficient copies are not available without cost, we sincerely hope you will purchase them from the Government Printing Office."

LABORATORY MANUAL OF MICROBIOLOGY FOR NURSES. *By E. S. Gill, B.S., R.N., and J. T. Culbertson, Ph.D. Illustrated. New York: G. P. Putnam's Sons.* 1947. *Pp.* 116. $1.50.

The extensive experience provided in this laboratory manual of microbiology for nurses may be attributed to the authors' belief that, if the student nurse is to have a complete understanding and appreciation of those basic nursing technics which are designed to prevent the spread of infection, it is necessary that thorough instruction be given as "to the nature of pathogenic organisms" and to the proper methods of handling them.

Little consideration is given to those microorganisms which are beneficial to man, such as the antibiotics of microbial origin, so that emphasis remains on the microbial property of pathogenicity. Laboratory exercises, of which there are 18, are arranged so that the student first works with nonpathogenic strains and then proceeds to those species of bacteria, spirochetes, yeasts, molds, as well as the protozoans, helminths and arthropods, which are pathogenic to human beings.

This general plan of instruction is rather well adhered to with perhaps the only exception being Exercise 2, "Staining of Bacteria," which precedes Exercise 5, "Inoculation of Culture Media." It would seem the latter exercise, which teaches the student technics of proper handling of these organisms, should logically come earlier than the staining technics.

An outstanding feature of this manual is the general outline used to present each exercise. Preceding the procedure directions, the materials, which will be needed to conduct the experiment, are listed. Antecedent to this list is a paragraph which serves to introduce to the student the contents and the purpose of the exercise. Spaces are provided to record observations in a well organized and meaningful manner. Each exercise also includes from six to 10 pertinent questions of a brief essay type. Answers to these questions can be written directly in the manual.

The physical organization of the manual contributes much to the legibility in that the lines are double spaced and the printed letter size is that of the elite typewriter. The seven illustrations which are simple linear drawings are inadequate to demonstrate satisfactorily such technics as the correct position to hold test tube plugs or to streak an agar plate.

Two appendices provide information for the student and the instructor regarding reagents and solutions and sources of materials. These are followed by a list of 13 books for reference. A number of errors, some of typographical nature and some inaccurate information, are found here. For example, the author's name, Burdon, is misspelled; the title of his book is given incorrectly, as is the date of publication. Despite the recent date of the manual's publication the list of books for reference does not include the latest editions of two texts, namely, the third edition of Burdon's "Textbook of Microbiology" and the seventh edition of Cecil's "Textbook of Medicine."

However, in summarizing, this latest addition to the short list of microbiology manuals is significant. Its inclusiveness is as outstanding as are its organization and presentation. Instructors should find it a valuable guide in teaching microbiology.—ANGELA DEL VECCHIO, R.N.

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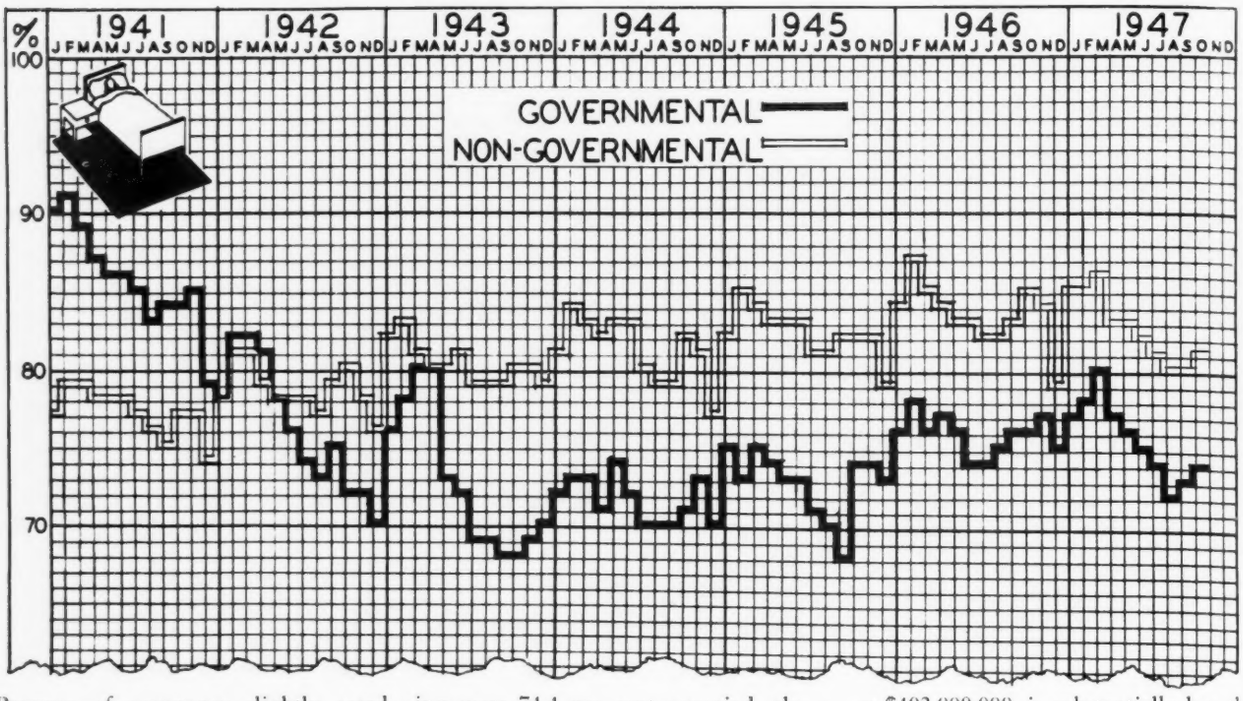
Voluntary Hospital Occupancy Below 1946 Figure



Pressure of occupancy slightly eased in hospitals reporting to the Occupancy Chart. For October, nongovernmental hospitals reported 81.2 per cent occupancy, up a little from the previous month but 3.5 per cent below October last year. Governmental hospitals reporting were 74.4 per cent occupied, also a little above September but less than October a year ago.

Construction projects reported for the November period totaled $88,199,318, as compared to $129,000,000 for the same period last year. The 1947 total to date, at $402,000,000, is substantially less than construction reported at this time last year, which totaled $472,000,000. Of 155 projects reported for the current period, 76 are new hospitals costing $36,302,771 and 74 are additions costing $28,817,480.

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